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ABSTRACT

This report concerns the medical malpractice situation in the United States and contains information on the cost of malpractice insurance for physicians and hospitals. The report contains an executive summary and four chapters. Chapter 1 reviews the background of the problem and the objectives, scope, and methodology of the report. Chapter 2 examines total malpractice premium costs for physicians in 1983 and in 1985 and average premiums by region and specialty, and concludes that physician medical malpractice insurance costs have increased, but they vary widely by location and specialty. Chapter 3 examines hospital malpractice costs and concludes that hospital medical malpractice insurance costs increased from 1983 to 1985, but varied by region and by size of institution. Chapter 4 looks at changes in hospitals' limits of coverage, sources of coverage, and other actions taken by hospitals and concludes that many hospitals increased total coverage limits while inpatient days decreased. Eight appendices, 44 data tables, and 2 figures are included. (NB)

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GAO

United States General Accounting Office

Report to Congressional Requesters

September 1986

MEDICAL MALPRACTICE

Insurance Costs Increased but Varied Among Physicians and Hospitals

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GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-221239

September 15, 1986

The Honorable John Heinz
Chairman, Special Committee
on Aging
United States Senate

The Honorable John Edward Porter
House of Representatives

In response to your requests and later discussions with your offices, we have undertaken a major effort to review the medical malpractice situation in the United States. This report, the second of a series we plan to issue on medical malpractice, contains information on the cost of malpractice insurance for physicians and hospitals. The first report, Medical Malpractice: No Agreement on the Problems or Solutions (GAO/HRD-86-50, Feb. 24, 1986), provided the views of major interest groups on the nature of malpractice problems and alternative approaches for resolving claims. Later reports will provide information on the malpractice situation in six states and the characteristics of malpractice claims closed in 1984.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies to interested parties and make copies available to others upon request.

Richard L Fogel

Richard L. Fogel
Assistant Comptroller General

Executive Summary

Purpose

How much does medical malpractice insurance add to the nation's health care costs? What are physicians and hospitals paying for malpractice insurance? How much have costs increased and how do they vary? The lack of sufficient data to answer these and other questions is hampering efforts by the Congress and others to determine how to address the concerns of health care providers about the high cost of insurance.

GAO made this review at the request of Representative John Edward Porter and Senator John Heinz, Chairman, Senate Special Committee on Aging, to develop current information on medical malpractice issues, including the cost of insurance for physicians and hospitals.

Background

The cost of medical malpractice protection for physicians and hospitals consists primarily of premiums for purchased insurance. For hospitals, however, the costs of malpractice also include contributions to self-insurance trust funds and payments made from general revenues and reserves for uninsured malpractice losses.

Malpractice insurance is but one of a number of expenses incurred by physicians and hospitals in doing business. Its cost can be put into perspective by viewing it individually and in comparison to total expenses and income.

To obtain data on malpractice insurance costs, GAO asked (1) leading insurers in all states and the District of Columbia to provide premium quotes for selected physician specialties as of July 1, 1985, and (2) a nationally representative sample of nonfederal hospitals about the sources, coverage limits, and costs of their malpractice insurance. GAO also obtained and analyzed data from the American Medical Association on physician gross income and practice expenses, including malpractice insurance, for self-employed physicians and from the American Hospital Association on hospital total expenses and net revenues.

GAO analyzed the hospital data in terms of cost per inpatient day, a commonly used measure for hospitals.

Results in Brief

From 1983 to 1985, total medical malpractice insurance costs for physicians and hospitals rose from $2.5 billion to $4.7 billion. The 100-percent increase in physicians' malpractice insurance costs and the 57-percent increase in hospitals' costs for that period are both much greater than the change in either the consumer price index or the medical care index, which increased by 8 and 13 percent, respectively. The medical care index is an element of the consumer price index relating to the cost of providing medical services. Indications are that insurance costs for physicians and hospitals will increase substantially in 1986.

Total malpractice insurance costs for physicians increased from $1.7 billion in 1983 to $3.4 billion in 1985. These costs varied widely by specialty, by state, and within some states. As a percentage of total professional expenses, malpractice insurance costs, which averaged 7 and 9 percent for all self-employed physicians in 1982 and 1984, respectively, are relatively small in relation to other expense items, such as nonphysician payroll and office expenses. However, from 1982 to 1984 malpractice insurance costs increased at a greater rate than did the other expense items. The highest premiums for medical malpractice insurance for physicians are primarily concentrated in high-risk specialties and in Florida, Illinois, Michigan, New York, and the District of Columbia.

Total malpractice insurance costs for hospitals increased from $800 million in 1983 to $1.3 billion in 1985. These costs varied by location and size of hospital and increased more than total expenses. During this same period about 1,920 hospitals increased their coverage limits. The effect of the increase in hospital malpractice insurance costs was compounded by a reduction in total inpatient days over the same period. As a result, the revenue base for recovering these costs has been reduced. Average inpatient day cost attributable to malpractice insurance, however, was about 1 percent of the average inpatient day expense for hospitals in 1983 and 1985.

GAO's Analysis

Physicians' Costs Varied Widely

The July 1, 1985, premium quotes GAO obtained from the leading insurer in each state and the District of Columbia showed that the annual cost of insurance varied widely by specialty and location. For example, for the same coverage limits and policy type, obstetricians/ gynecologists in Utah, upstate New York, and Long Island, New York, would have paid $13,376, $30,818, and $68,116, respectively. In contrast, physicians in the same three locations with the same coverage limits and policy type who practiced internal medicine and performed no surgery would have paid $2,015, $6,069, and $13,413, respectively. Insurance costs for obstetrics/gynecology increased more than those of other specialties. From 1982 to 1984 (the latest year for which data were available from the American Medical Association), average insurance costs for self-employed physicians increased by 45 percent, with increases ranging by specialty from 21 percent for pediatrics to 72 percent for obstetrics/gynecology.

Premiums Are a Small Part of Costs and Income

Premium costs rank fourth on the list of five major expense items for self-employed physicians. These items are nonphysician payroll, 33 percent; office expense, 26 percent; medical supplies, 11 percent; malpractice professional insurance, 9 percent; and medical equipment, 6 percent. Premium costs increased more than any of the other major cost elements, with increases ranging from 1 percent for nonphysician payroll to 45 percent for malpractice insurance. As a percentage of gross income, premium costs varied by specialty and ranged from 2 percent for internal medicine to 8 percent for obstetrics/gynecology.

Hospital Daily Inpatient Costs Almost Doubled

From 1983 to 1985, the average hospital malpractice insurance cost per inpatient day increased by 85 percent—from $3.02 to $5.60. The inpatient day cost of malpractice insurance was determined by dividing total malpractice insurance cost by total inpatient days. During the 1983-85 period, total inpatient days decreased by about 13 percent from 267 million to 232 million, while total malpractice insurance costs increased by about 57 percent from $849 million to $1.336 billion. The increase in average inpatient day malpractice insurance costs over this period is much greater than the 26-percent increase in expenses per inpatient day, which rose from $392 to $494.

The range of malpractice insurance costs and the amount of increase per inpatient day varied considerably. In 1985, for example, about 49 percent of the hospitals had malpractice insurance costs of $3 or less, while 12 percent had costs of more than $10 per inpatient day. Although changes in inpatient day costs from 1983 to 1985 varied widely, about 39 percent of the hospitals had increases in inpatient day costs of 100 percent or more from 1983 to 1985.

Hospital Costs Varied by Size and Region

Average inpatient day malpractice insurance costs varied by region and size of hospital. The smallest hospitals (under 50 beds) have the lowest cost, and the largest hospitals (500 beds and over) generally have the highest costs. However, hospitals with very large percentage increases in malpractice insurance costs between 1983 and 1985 were concentrated among the smaller hospitals (under 50 beds). For example, about 38 percent of the hospitals experiencing increases in average inpatient day insurance costs of 200 to 299 percent had under 50 beds.

A number of hospitals also provided comments indicating that while insurance costs were rising, the revenue base over which these costs could be spread was decreasing as inpatient days declined and new cost containment regulations or eligibility restrictions were initiated by the states and the federal government. This put them in a "squeeze" situation, in which they were not able either to absorb the premium cost increases without adverse effects on operations or to pass on the increases to patients or other purchasers.

Recommendations

This report contains no recommendations.

Agency Comments

GAO did not obtain comments on this report.

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Abbreviations

AHA	American Hospital Association
AMA	American Medical Association
CPI	consumer price index
GAO	General Accounting Office
MCI	medical care index
SMS	Socioeconomic Monitoring System

Chapter 1
Introduction

At the request of Representative John Edward Porter and Senator John Heinz, Chairman of the Senate Special Committee on Aging, we undertook a review of medical malpractice issues. The objectives of our review were to develop information for the Congress on:

1. The views of major medical, legal, insurance, and consumer interest groups about the existence and nature of any current or impending malpractice problem.

2. Alternative approaches to resolving medical malpractice claims.

3. The economic costs attributable to medical malpractice, primarily the direct costs of malpractice insurance for physicians and hospitals.

4. The medical malpractice situation in six selected states (Arkansas, California, Florida, Indiana, New York, and North Carolina).

5. The characteristics of a national sample of malpractice claims closed during 1984, including the allegations of negligence leading to claims, severity of injuries, economic losses of injured patients, compensation paid, and time required to close the cases.

The first in a series of reports we plan to issue on these matters, Medical Malpractice: No Agreement on the Problems or Solutions (GAO/HRD-86-50, Feb. 24, 1986), focused on the views of major interest groups concerning malpractice problems and alternative approaches to resolving malpractice claims. That report presented the perception of health care provider organizations that the high cost of medical malpractice insurance was a major problem. This report presents information on the cost of malpractice insurance for physicians and hospitals. Later reports will provide information on the current malpractice situation in the six states and the characteristics of malpractice claims closed in 1984.

Background

There are both direct and indirect costs associated with medical malpractice. The direct costs are primarily related to the cost of malpractice insurance. The indirect costs include (1) the lost productivity of physicians defending against malpractice claims, (2) the reduced access to care when physicians discontinue practicing in certain locations and specialties or refuse to perform certain procedures, and (3) the increased cost of health care resulting from the practice of defensive medicine.

Defensive Medicine

Defensive medicine has been defined as:

> "The alteration of modes of medical practice, induced by the threat of liability, for the principal purposes of forestalling the possibility of lawsuits by patients as well as providing a good legal defense in the event such lawsuits are instituted."[1]

Health care providers responding to the threat of malpractice litigation may (1) perform additional diagnostic tests and/or treatment procedures, (2) maintain more detailed patient records, (3) increase the number of follow-up visits by patients, and (4) spend more time with patients. The Association of Trial Lawyers of America has stated that this type of "defensive medicine" is merely careful medicine. The American Medical Association (AMA), on the other hand, has stated that these practices are not dictated by medical need but by the perceived need to reduce the risk of incurring a malpractice claim. As such, they state, these practices are of marginal benefit to patients and do not justify the added cost. The threat of medical malpractice litigation may also induce some physicians to refuse to perform certain high-risk procedures, to change their specialty or the location of their practice, or retire early.

The cost of defensive medicine is impossible to quantify with any degree of confidence because of the difficulty in developing a sound methodology to isolate "defensive" practices from medical care provided for good clinical reasons. In 1985, AMA estimated the annual cost of defensive medicine to be about $15 billion.

Elements of Malpractice Insurance

Most health care providers (physicians and hospitals) purchase professional liability insurance to protect themselves from medical malpractice claims. Under the insurance contract, the insurance company agrees to accept financial responsibility for paying any claims up to a specific limit of coverage during a fixed period in return for a fee. The insurer investigates the claim and defends the health care provider. However, in addition to or in place of purchased insurance, some hospitals self-insure all or part of their medical malpractice risk. Others make no formal provision for coverage but pay losses as they are incurred from general revenues and reserves. Insurance companies buy reinsurance from other insurers to cover potential losses that may be too large for the individual company to absorb.

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[1] Report of the Secretary's Commission on Medical Malpractice, Department of Health, Education, and Welfare, 1973.

Variation of Rates

Malpractice insurance rates for physicians vary by specialty and geographic location and generally increase in proportion to the amount and complexity of surgery performed. Rates may vary from state to state and within a state. For rate purposes, insurance companies usually group physician specialties into distinct classes. Each class represents a different level of risk for the company.

The number and composition of rate classes may vary from company to company. For example, the St. Paul Fire and Marine Insurance Company uses 8 rate classes for physicians, whereas the Medical Liability Mutual Insurance Company of New York uses 14. Rates are typically determined based on the claims experience of the class rather than that of the individual physician. Some insurance companies assess a surcharge, in addition to the standard rate, for physicians with an unfavorable malpractice claims experience.

Malpractice insurance rates for hospitals are frequently based on the malpractice loss experience (in term of numbers of claims filed and the amount per paid claim) of the individual hospital. For example, in determining its rates, the St. Paul Company includes a factor to adjust its standard rates for each hospital's historical malpractice loss experience.

Types of Policies

Malpractice insurance is written on either an occurrence or a claims-made basis. An occurrence policy covers malpractice events that occurred during the policy period, regardless of the date of discovery or when the claim may be filed. A claims-made policy covers malpractice events that occurred after the effective date of the coverage and for which claims are made during the policy period. Premiums for claims-made policies are generally lower at first because the risk exposure to the insurer is lower, but premiums increase each year the health care provider is covered until the 5th year, when they mature or stabilize.

Generally, even if the expected number of claims and size of awards/settlements were the same for both policy forms, the occurrence rate will be higher than the mature claims-made rate for identical limits of coverage. This is because the uncertainty involved in projecting losses that will not be reported for some years into the future (occurrence policy) is greater than that involved in projecting losses to be reported in the current year (claims-made policy).[2] According to Joseph B. Nardi, President of the St. Paul Medical Services Division, claims-made pricing is more accurate because it is based on claims already reported to the company, whereas the pricing of an occurrence policy is based not only on known claims, but also on speculative projections of claims yet to be reported in a legal environment yet to be experienced.[3]

To cover claims filed after a claims-made policy has expired (such as would occur when the health care provider changes insurers or discontinues providing medical services), the health care provider may purchase insurance known as a reporting endorsement or "tail" coverage. The St. Paul Company has stated that it bases the cost of tail coverage for physicians and hospitals on the rates, and thus the legal environment, in existence when the coverage is purchased.

Coverage Limits

Typically, medical malpractice insurance policies have a dollar limit on the amount that the insurance company will pay on each claim against the insured (per-occurrence limit) and a dollar limit for all claims against the insured (aggregate limit) for the policy period, usually 1 year. For example, limits of coverage of $1,000,000/$3,000,000 mean that the insurer will pay up to $1,000,000 on a single claim and up to $3,000,000 for all claims against the insured during a policy year. The higher the limits of coverage, the greater the cost of the insurance; however, cost does not increase in direct proportion to increasing limits of coverage. Small or moderately sized claims occur more frequently than do very large claims.

Health care providers may purchase medical malpractice insurance coverage in layers from different sources if the limits required by state law or desired by the provider cannot be obtained from a single source. For example, some states have patient compensation funds or catastrophic loss funds, which work in combination with insurance purchased from an insurance company. Physicians in Pennsylvania, for example, are required to have $1,200,000/$3,600,000 in malpractice coverage. The first $200,000/$600,000 is obtained from an insurance company, and the next $1,000,000/$3,000,000 from the state-operated catastrophic loss fund. A Pennsylvania physician desiring coverage beyond the required level would then have the option of purchasing additional limits of coverage from the same insurance company writing the $200,000/$600,000 limits or from another company.

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[2] Myron F. Steves, Jr., "Medical Professional Liability" from Professional Liability in the Eighties, a monograph published by the Society of Chartered Property and Casualty Underwriters, Fall 1983, pp. 99-100.

[3] "Physician and Surgeons' Update," St. Paul Fire and Marine Insurance Company, 1984, p. 3.

Deductibles

Because small and moderately sized claims occur more frequently than very large claims, insureds who assume a portion of this risk through a deductible can reduce their insurance premiums. Under a policy with a deductible provision, an insurer is liable only for losses in excess of a stated amount up to the policy limits. For example, if a hospital incurred a $300,000 malpractice loss while insured under a $1,000,000 per-occurrence policy with a $100,000 deductible, the hospital would pay $100,000 of the loss and the insurer would pay $200,000. Generally, the higher the deductible, the greater the premium savings.

Some hospitals with a deductible provision "insure" this risk by establishing a self-insurance trust fund. Others pay these losses as they are incurred from general revenues and reserves.

Medical Malpractice Insurance Market Conditions From 1980 to 1985

During the 1980-85 period, the medical malpractice insurance market was significantly affected by increasing payments for malpractice claims, declining interest rates, and a tightening of the reinsurance market. These factors, as discussed below, contributed to increased costs of malpractice insurance for physicians and hospitals.

Increasing Loss Payments

The number (frequency) of claims and the average paid per paid claim (severity) are the primary factors that affect the cost of insurance. During the 1980-85 period, both the number and the severity of claims were increasing. As a result, the total payments made by malpractice insurers were increasing.

According to the St. Paul Company, which in 1985 insured more than 55,000 physicians in 44 states and about 1,555 hospitals in 47 states, both the frequency and severity of claims for physicians and hospitals have been increasing. The number of claims reported per 100 physicians increased from 10.5 in 1980 to 15.1 in 1983 to 17.8 in 1985—an overall increase of about 70 percent since 1980. The number of claims filed per 100 occupied hospital beds increased from 2.1 in 1980 to 3.0 in 1983 to 4.3 in 1985—an overall increase of about 104 percent. For physicians, the average amount paid on claims closed with payment increased from $28,059 in 1980 to $53,380 in 1983 to $70,170 in 1985—an overall increase of about 150 percent. For hospitals, the average amount paid on claims closed with payment increased from $12,802 in 1980 to $26,735 in 1983 to $40,281 in 1985—an overall increase of about 215 percent.

Declining Interest Rates

Bonds are generally the largest single type of asset held by property/casualty insurers.[4] Mavis Walters, Senior Vice President of Insurance Services Office,[5] stated that there was no reason to believe this would be markedly different for medical malpractice insurers. From the time provider-owned malpractice insurance companies began entering the market in the mid-1970's until mid-1984, interest rates on bonds generally increased. The movement of interest rates on Moody's Corporate Aaa Seasoned Issues (long-term bonds), for example, shows that rates increased from January 1978 to September 1981, reaching a high of 15.49 percent. After decreasing to 11.46 percent in May 1983, interest rates on these bonds began increasing again, reaching 13.55 percent in June 1984. From June 1984 through December 1985, interest rates steadily declined. In December 1985, the rate on Moody's Corporate issues was 10.16. The general direction in the movement of rates during this time was the same for other bonds, such as U.S. Government 10-Year Constant Maturity Bonds and Moody's Aaa State and Local Bonds.

The objective in establishing insurance premium rates is to develop rates that will be appropriate for the period during which they apply. To be appropriate, the rates must generate funds to cover (1) losses occurring during the period, (2) administrative costs of running the company, and (3) an amount for unknown contingencies, which may become a profit if not used.

When interest rates were rising in the late 1970's and early 1980's, malpractice insurers were engaged in intensive competition for market share. According to Ms. Walters, many companies priced their malpractice policies below actuarially indicated levels in order to be competitive and in recognition of the investment income that would be earned at the existing high interest rates. This practice, employed by property/casualty insurers in general as well as medical malpractice insurers, is referred to as "cash flow underwriting." Ms. Walters stated that when interest rates declined, insurers began to raise prices closer to actuarially indicated levels, now recognizing lower levels of investment income.

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[4] Terrie E. Troxel, et al., Property-Liability Insurance Accounting and Finance, American Institute for Property and Liability Underwriters, 1983, p. 63.

[5] The Insurance Services Office is a nonprofit corporation that makes available rating, statistical, actuarial, policy form, and related services to any U.S. property/casualty insurer.

Tightening of Reinsurance Market

The reinsurance market was also affected by increasing payments made on claims by insurers and decreasing interest rates. The net effect was a tightening of the reinsurance market resulting in higher insurance costs, less availability of higher coverage limits, more restrictive terms and policy restrictions when limits are available, and greater assumption of losses on the part of insurers.

Reinsurance allows companies to share their risks with other companies and to stabilize insurance losses, which may fluctuate considerably. The capacity (annual net premiums written in relation to policyholders' surplus, i.e., owners' equity) and willingness of the international reinsurance market to accept part of the risk for potential malpractice losses is important to ensuring the availability of medical malpractice insurance.

According to the St. Paul Company in 1985, recent deteriorating underwriting results (losses in relation to premiums earned) of malpractice insurance companies caused some reinsurance companies to withdraw from or reduce their involvement in the malpractice insurance market. The St. Paul Company stated that reinsurers that continue to provide malpractice coverage are increasing the premiums they charge insurance companies and that some reinsurers are requiring insurers to assume more of each loss and, therefore, absorb more total losses. The St. Paul Company added that some reinsurers have refused to reinsure occurrence malpractice policies or have reduced coverage limits they will offer.[6]

During the period of high interest rates, reinsurers were also highly competitive for market share. As with primary insurers, this competition was reflected in lower than actuarially indicated insurance prices. According to John C. Etling, President of General Reinsurance Corporation,[7] as long as interest rates remained high, the poor underwriting results were masked. He stated, however, that when interest rates turned in 1984 and the losses appeared, the immediate reaction of both insurers and reinsurers was to stop the losses, raise rates, cancel business, withdraw from markets, and cut lines of insurance written and classes of risks assumed.

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[6] "The St. Paul's Hospital Update," St. Paul Fire and Marine Insurance Company, 1985, p. 4.

[7] Presentation at the 10th International Captive Insurance and Reinsurance Forum, March 1986, as reported in Business Insurance, April 4, 1986.

Objectives, Scope, and Methodology

Our overall objective was to develop information on the direct cost of medical malpractice insurance for physicians and hospitals. To accomplish this, we (1) requested the leading insurers of physicians in the 50 states and the District of Columbia to provide their rates for selected physician specialties as of July 1, 1985, and (2) surveyed 1,782 hospitals in those 51 jurisdictions regarding their sources, coverage limits, and costs of malpractice insurance for policy years 1983-85.

Physician Costs

To develop information on trends in physicians' medical malpractice insurance costs, we obtained and analyzed reports from AMA's Profile of Medical Practice and Socioeconomic Monitoring System (SMS). Both of these sources provide information on physician income and expenses.

Through annual surveys, AMA collects earnings and expense data on physicians involved in patient care activities. Physicians are chosen from a stratified sample selected from the AMA Physician Masterfile. The Masterfile contains current and historical information on the professional activities, such as type of practice (patient care or nonpatient care) and specialty of every known physician in the United States. AMA then reports its information in terms of averages for each calendar year. Because AMA data for 1985 will not be available until the fall of 1986 and there was a change in data collection methodology as well as incomplete malpractice insurance information in 1981, a transition year, AMA data for the years 1981 and before were not comparable to later years. Therefore, we limited our use of AMA data to the 1982-84 period.

Further, during this period AMA reported expense data for only self-employed physicians while reporting net income for both self-employed and employee physicians. Thus, we used the AMA data for self-employed physicians to maintain consistency in our analysis. As for physician specialties, although SMS has 10 reporting classifications, during the 1982-84 period, AMA consistently reported complete income and expense (including malpractice insurance) data for only the following five specialties: general/family practice, internal medicine, pediatrics, surgery, and obstetrics/gynecology. These were the AMA specialties used in our trend analysis for the 1982-84 period.

We independently obtained malpractice premium rate quotes as of July 1, 1985, for primary[8] limits of coverage for each of seven physician specialties. To obtain the range of malpractice premiums from low- to high-risk specialties, we selected the following specialties shown in ascending order of risk, as classified by the Insurance Services Office.

- Internal Medicine (no surgery).
- General/Family Practice (minor surgery).
- General Surgery.
- Anesthesiology.
- Obstetrics/Gynecology.
- Orthopedic Surgery.
- Neurosurgery.

The rate quotes were obtained from the leading insurer of physicians in each of the 50 states and the District of Columbia for the predominately purchased limits of primary coverage for each selected specialty. We identified, from each state's medical society, the company that was the leading insurer based on the largest number of physicians insured. In July 1985, we requested each state's leading insurer to (1) identify, for the most recently completed policy year, the predominate malpractice insurance coverage limits purchased from that company in that state by physicians in each of the seven specialties, (2) provide premium rate quotes[9] as of July 1, 1985, for each selected specialty for each unique pricing territory in the state, and (3) provide the number of physicians insured in each specialty by the company in the state.

Hospital Costs

To obtain information on hospital costs, we sent a questionnaire (see app. VI) to 1,782 community hospitals,[10] asking them to provide data on their professional liability insurance. We asked hospitals to provide information regarding the sources, coverage limits, and costs of both their primary and above-primary levels[11] of coverage for their policy years ending in 1983, 1984, and 1985. In addition, we asked each to provide data on the number of inpatient days, outpatient visits, and emergency room visits and problems experienced or expected in obtaining insurance for the 1986 policy year. Seventy percent, or 1,248 hospitals, returned completed questionnaires as of February 28, 1986. We also obtained hospital total expense and net revenue data for the 1983-85 period from the American Hospital Association (AHA).

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[8] The first layer of insurance coverage is commonly known as basic or primary coverage.

[9] We obtained rates for the type of policies written by the leading insurers. For a claims-made policy, we asked for the mature rate (usually after 5 years).

[10] Community hospitals, as defined by the American Hospital Association, are all nonfederal short-term general (average stay of less than 30 days) and other special hospitals, excluding hospital units of institutions.

[11] We refer to the basic level of insurance liability coverage as primary and the coverage above the basic level as excess or above-primary coverage.

The 1,782 sample hospitals were randomly selected from 5,783 community hospitals reported for the 50 states and the District of Columbia[12] in AHA's 1984 Edition of Hospital Statistics. The 1984 Edition presented statistical data—by hospital size (number of beds) and geographic location among other things—obtained through AHA's 1983 Annual Survey of Hospitals.

At our request, AHA randomly selected a sample of hospitals from a stratified universe. According to AHA's sample design, the universe was divided into 72 strata reflecting eight hospital sizes within each of the nine census regions (see app. I). This design permitted us to analyze individual regions and hospital sizes but did not permit analysis by hospital size within regions. The AHA sample was weighted so that proportionately more large hospitals were selected because of perceived greater variability among such hospitals.

We pretested several drafts of our questionnaire by mail at hospitals of various sizes selected throughout the nine regions and by in-person visits to hospitals in the Washington, D.C., metropolitan area. The information obtained was used to refine the questions and terminology used in the final questionnaire.

We initially mailed the 1,782 questionnaires on July 29, 1985, with follow-up mailings to nonrespondents on September 20, 1985; November 13, 1985; and January 31, 1986. We pledged to keep confidential the names of individual hospitals participating in the survey.

As we received the completed questionnaires, we reviewed the data provided for consistency and completeness before coding the responses for keying into our data base. Where data items appeared inconsistent or incomplete, we contacted the hospital personnel by telephone and attempted to obtain the missing data or resolve the inconsistencies; however, some hospitals could not provide all of the data requested. We did not verify the accuracy of the data provided. Appendix VII provides statistical information on the universe, our sample, and the respondents by hospital size and census region.

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[12] Hospitals in the U.S. territories were excluded from our study universe.

Some of the hospitals provided reasons for not completing the questionnaires. The reasons cited included lack of staff, time constraints, and the complexities involved in obtaining the data because of affiliation with a multihospital system. Based on our tests of nonrespondents by region, hospital size, and ownership, we believe the characteristics of these hospitals would not be much different from the responding hospitals.

We primarily performed our analysis by nine geographic census regions and seven hospital size ranges. The responses from hospitals in the two smallest size ranges (as shown in app. VII) were combined to improve the reliability of our estimates for the smaller hospitals where we had lower response rates.

We also analyzed some of the data according to the sources used by the hospitals to protect themselves from malpractice claims—self-insurance trust funds, purchased insurance, or combination of self-insurance and purchased. A self-insurance trust fund is a reserve fund which is maintained in a segregated account by an intermediary and to which the hospital makes contributions generally on an annual basis. Purchased insurance includes state catastrophic funds or patient compensation funds as well as insurance provided by commercial carriers and hospital-owned insurers. Our analysis of coverage limits was based on the total primary and above primary per-occurrence limits obtained through self-insurance and/or purchased insurance.

For our cost analyses, total hospital malpractice costs include contributions to self-insurance trust funds, premiums for purchased insurance, and uninsured losses. We determined the medical malpractice insurance cost per inpatient day by dividing the total malpractice costs by the number of inpatient days since most of the malpractice exposure and insurance cost is related to inpatient services. For example, in developing hospital malpractice insurance rates, the St. Paul Company considers 2,000 outpatient visits to be equivalent in risk exposure to one hospital bed which could produce 365 inpatient days. Hospitals pretesting our questionnaire were generally not able to distinguish between the portion of their total malpractice insurance costs attributable to inpatient versus outpatient services. AHA computes an average expense per inpatient day by multiplying total expenses by the ratio of total net (of contractual adjustments, bad debts, charity, and so forth) inpatient revenue to total net patient revenue and dividing the result by the total number of inpatient days. Using AHA data on inpatient days and outpatient visits and prorating malpractice insurance costs on the basis of 2,000 outpatients equaling 365 inpatient days, the cost of malpractice insurance for outpatient services as a percentage of the total cost of malpractice insurance would have been 13.7 percent in 1983, 14.9 percent in 1984, and 16.4 percent in 1985.

Our estimates are based on weighting procedures applied to our 1,248 responding hospitals' data by a statistical analysis package. In instances where data elements were missing from a hospital's response (e.g., 1983 cost data), the estimated values will be for less than the total number (5,783) of hospitals in the universe. We verified a random sample of the data entered into the programs and tested the programs to ensure the reliability of our analyses.

The sampling errors are stated at the 95-percent confidence level. This means that, with the data collected, the chances are 19 out of 20 that the results obtained would not differ from the estimates by more than the sampling error shown for each estimate. The values discussed in this report and their sampling errors are presented in appendix VIII. We performed our work in accordance with generally accepted government audit standards.

We did not attempt to determine why malpractice insurance costs vary among physician and hospitals or whether malpractice insurance rates were reasonable based on claims experience.

Physician Medical Malpractice Insurance Costs Increased but Varied Widely by Location and Specialty

A major part of the debate concerning medical malpractice focuses on the premiums being paid by physicians, the extent to which they are increasing, and the percentage of total expenses that they represent. Some physicians and physician organizations argue that malpractice insurance costs are high and rising rapidly and that this is forcing some physicians to practice defensive medicine, change practice specialties, discontinue certain services and procedures, or retire early. The Association of Trial Lawyers of America argues, however, that malpractice premiums represent a small cost of doing business.

Total premiums paid by private patient care physicians[1] increased from $1.7 billion in 1983 to $3.4 billion in 1985. These increases far exceeded increases in the consumer price index (CPI) and medical care index (MCI) over the same period. The rates and increases, however, varied considerably by specialty and geographic location. Based on rates we obtained as of July 1, 1985, physicians practicing orthopedic surgery, neurosurgery, and obstetrics/gynecology generally paid the highest premiums. According to the latest AMA data, physicians in these specialties represented about 11 percent of the total private patient care physicians.[2] Rates paid by physicians in these and other specialties varied considerably, however, from state to state and even within some states. For example, based on rate quotes we obtained from each state's leading insurer, in 1985 a Long Island, New York, obstetrician/gynecologist purchasing coverage limits of $1,000,000/$3,000,000 would have paid $68,116, while an obstetrician/gynecologist in Utah would have paid $13,376 for the same limits. For coverage limits of $1,000,000/ $1,000,000 in 1985, physicians practicing general/family medicine would have paid a premium of $18,229 in Dade and Broward Counties in Florida, but $2,760 in North Carolina.

As a percentage of average total professional expenses, average malpractice premiums for self-employed physicians increased from 7 percent in 1982 to 9 percent in 1984. Again, there was significant variance by specialty. In 1984, for example, average premiums for self-employed general and family practitioners were about 5 percent of average total expenses, but average premiums for self-employed obstetrician/ gynecologists were 16 percent of total expenses.

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[1] Does not include physician teachers, researchers, and administrators.

[2] Physician Characteristics and Distribution in the U.S., 1984 Edition, Department of Data Release Services, Division of Survey and Data Resources, American Medical Association, 1985, p. 112.

Total Malpractice Premiums for Physicians Doubled From 1983 to 1985

AMA[3] estimates that total premiums paid by the over 400,000 private patient care physicians increased by 100 percent from 1983 to 1985. Indications are that physician-owned companies, which insure more than half of practicing physicians, will increase their 1986 malpractice insurance rates substantially. The Medical Liability Monitor[4] of February 27, 1986, reported that, in its telephone survey of 35 physician-owned companies, 21 indicated that they will seek rate increases averaging about 40 percent for 1986.

While the 1983-85 increases are significant, some groups, such as the American Trial Lawyers Association, believe that using these figures to indicate that physician malpractice premiums are at a crisis level is misleading because total physician premiums still make up less than 1 percent of the country's total health care costs, which were about $390 billion in 1984.

Two other key measures can be used in analyzing physician premiums. These are the CPI and the MCI.[5] As shown in table 2.1, physician premiums for the 1983-85 period have increased more than either of these indexes.

Table 2.1: Comparative Percent Increases for Physician Premiums and Consumer Price and Medical Care Indexes From 1983 to 1985

Dollars in billions

	Physician premiums		CPI		MCI	
	Amount	Percent increase	Index	Percent increase	Index	Percent increase
1983	$1.7	•	298.4	•	357.3	•
1985	3.4	100	322.2	8	403.1	13

Average Premiums Varied by Region

Average malpractice insurance premiums for self-employed physicians varied considerably among the census regions.[6] AMA collects data on self-employed physician expenses, including malpractice insurance costs, and reports this information in terms of averages. Table 2.2 shows that average premiums each year varied by region and increased for every region from 1982 to 1984.

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[3] Unless otherwise indicated, physician data are from AMA's SMS.

[4] A monthly newsletter that reports medical, professional liability news.

[5] The CPI measures the average change in prices in a market basket of goods and services, while the MCI, a CPI element, measures the average change in prices for medical care commodities and services.

[6] See appendix I for the U.S. census regions.

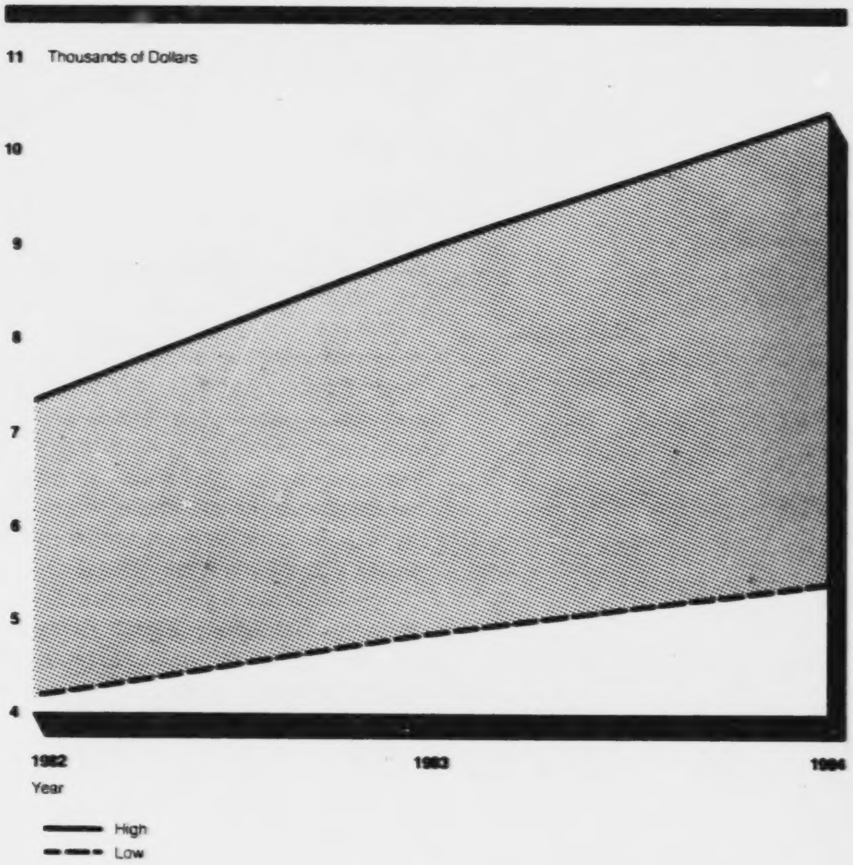
Table 2.2: Physician Average Premiums and Percent Increase From 1982 to 1984 by Census Region

	Physician premiums			
Region[a]	**1982**	**1983**	**1984**	**Percent increase**
1	$5,500	$7,100	$7,300	33
2	7,400	8,800	10,400	41
3	5,700	6,300	8,600	51
4	5,400	7,200	7,700	43
5	4,600	5,900	6,500	41
6	5,200	4,900	8,300	60
7	4,200	5,100	5,400	29
8	5,600	6,600	7,500	34
9	6,700	9,000	10,000	49

[a] See appendix I for the U.S. census regions. Region 1 is New England, 2 is the Middle Atlantic, 3 is the South Atlantic, 4 is the East North Central, 5 is the East South Central, 6 is the West North Central, 7 is the West South Central, 8 is Mountain, and 9 is Pacific.

Furthermore, as illustrated in figure 2.1, the difference in average premiums between the regions with the highest and lowest average premiums has increased. This gap widened principally because, from 1982 to 1984, in region 2, the region with the highest average premium paid, the average premium increased by about 41 percent—from $7,400 to $10,400—while in region 7, the region with the lowest average premium, the average premium increased by about 29 percent—from $4,200 to $5,400.

Figure 2.1: High and Low Average Premiums Nationwide for 1982 to 1984



Average Premiums Were Higher for All Specialties but Increased More for Obstetrics/Gynecology

Average premiums varied by specialty[7] and were generally higher for specialties involving surgery. As shown in table 2.3, the average premium for all self-employed physicians increased from $5,800 in 1982 to $8,400 in 1984—about a 45-percent increase. Pediatrics had the lowest increase, about 21 percent, from $2,900 in 1982 to $3,500 in 1984. Average premiums increased for obstetrics/gynecology from $10,900 in 1982 to $18,800 in 1984—about a 72-percent increase.

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[7] During the 1982-84 period, AMA consistently reported complete income and expense data for self-employed physicians, including medical malpractice insurance data, for only five specialties. Therefore, we limited the trend analysis to these specialties.

Table 2.3: Physician Average Premiums and Percent Increase From 1982 to 1984 by Specialty

Specialty	Physician premiums 1982	 1983	 1984	Percent increase
All physicians	$5,800	$7,100	$8,400	45
General/family practice	3,500	4,400	4,600	31
Internal medicine	3,700	4,400	4,900	32
Surgery	9,900	10,900	13,400	35
Pediatrics	2,900	3,900	3,500	21
Obstetrics/gynecology	10,900	14,100	18,800	72

Average Premiums Were a Small Percentage of Average Total Expenses but Increased More Than Other Expenses

Malpractice insurance was the fourth largest of five expense items. As a percentage of average total expenses for self-employed physicians, average malpractice premiums were small but increased more than other expenses between 1982 and 1984. As shown in table 2.4, these expense items included (1) nonphysician payroll, (2) office expenses, (3) medical supplies, (4) insurance, and (5) medical equipment. Average insurance premiums increased from 7 percent of average total expenses in 1982 to 9 percent in 1984. In absolute dollars, premiums increased about 45 percent. As a percentage of average total expenses, the largest item, nonphysician payroll, decreased from 39 to 33 percent even though these costs increased slightly from $30,400 in 1982 to $30,600 in 1984. Average medical equipment costs, the smallest item, remained at 6 percent of average total expenses even though they increased from $4,900 in 1982 to $5,500 in 1984, or about 12 percent.

Table 2.4: Physician Average Expenses as Percentages of Average Total Expenses and Percent Change From 1982 to 1984

Physician expense	1982 Amount	 Percent	1983 Amount	 Percent	1984 Amount	 Percent	Percent change
Total	**$78,400**	•	**$85,900**	•	**$92,600**	•	**+18**
Nonphysician payroll	30,400	39	29,200	34	30,600	33	+1
Office expenses	17,500	22	21,000	24	24,000	26	+37
Medical supplies	7,800	10	9,200	11	10,500	11	+35
Malpractice insurance	5,800	7	7,100	8	8,400	9	+45
Medical equipment	4,900	6	5,100	6	5,500	6	+12

Note: Expenses do not add to total because more physicians were able to answer the AMA question on total expenses than could answer questions on the individual expense items.

Table 2.5 shows the trend in physician average expenses for five specialties. For general/family practice, internal medicine, and pediatrics, average insurance costs as a percentage of average total expenses in

1982 and 1984 ranged from 4 to 6 percent, while for surgery and obstetrics/gynecology, the range was 9 to 16 percent.

Table 2.5: Physician Average Expenses as Percentages of Average Total Expenses by Specialty for 1982 and 1984

	General/family practice		Internal medicine		Pediatrics		Surgery		Obstetrics/ gynecology	
	1982	1984	1982	1984	1982	1984	1982	1984	1982	1984
Nonphysician payroll	42	35	39	36	39	37	37	33	43	30
Malpractice insurance	5	5	5	6	4	5	9	10	10	16
Medical equipment	6	6	7	5	4	5	7	7	7	6
Office expenses	23	26	25	25	26	30	21	25	23	26
Medical supplies	15	16	10	13	12	13	8	11	9	11
Other expenses	9	12	14	15	15	10	18	14	8	11

Average Premiums Were a Small Percentage of Average Gross Income

In 1984, average premiums for self-employed physicians represented 4 percent of their average gross income,[8] which was $187,400 in 1982 and $211,200 in 1984. Table 2.6 shows premium costs and other physician average expenses in relation to average gross income.

Table 2.6: Physician Average Expenses as Percentages of Average Gross Income for 1982 and 1984

	1982		1984	
	Amount	Percent	Amount	Percent
Average gross income	$187,400	•	$211,200	•
Professional insurance	5,800	3	8,400	4
Nonphysician payroll	30,400	16	30,600	15
Office expenses	17,500	9	24,000	11
Medical supplies	7,800	4	10,500	5
Medical equipment	4,900	3	5,500	3

AMA data indicate that insurance takes up a larger portion of average gross income for obstetrics/gynecology than it does for other specialties. As shown in table 2.7, the average obstetrics/gynecology insurance costs ranged from 5 percent of average gross income in 1982 to 8 percent in 1984.

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[8] We calculated physician gross income from data reported by SMS by summing the average net income and the average professional expenses of self-employed physicians.

Table 2.7: Physician Average Premiums as Percentages of Average Gross Income for 1982 and 1984 by Specialty

	1982		1984	
Specialty	**Premiums**	**Percent**	**Premiums**	**Percent**
Pediatrics	$2,900	2	$3,500	2
General practice	3,500	2	4,600	3
Internal medicine	3,700	2	4,900	2
Surgery	9,900	4	13,400	5
Obstetrics/gynecology	10,900	5	18,800	8

1985 Rates Varied Widely by State and Specialty

Physician malpractice insurance rates varied significantly among specialties in every state. Moreover, there were significant differences in premiums for each specialty across states. Our analysis of the nationwide rate quotes shows that, as of July 1, 1985, the premiums of $50,000 and above were concentrated in four states and the District of Columbia. Florida and New York had high premiums ($50,000 or above) for neurosurgery, obstetrics/gynecology, and orthopedic surgery; Michigan and the District of Columbia for neurosurgery; and Illinois for neurosurgery and orthopedic surgery. Tables 2.8 and 2.9 show the malpractice insurance premiums by state for the predominately purchased coverage limits and policy form for internal medicine and neurosurgery—the specialties with the lowest and highest malpractice insurance premiums. For internal medicine (no surgery), premiums ranged from $8,445 in Michigan to $1,293 in Indiana. For neurosurgery, premiums ranged from $64,696 in Florida to $9,150 in South Carolina. (See app. II for premium information on the other five specialties.)

Table 2.8: Malpractice Insurance Premiums Paid by Physicians in Internal Medicine (No Surgery) **by State as of July 1, 1985**

State	Premium	Coverage limits[a]	Policy form[b]
MI[c]	$8,445	$1/$1	O
IL[c]	7,420	1/3	O
FL[c]	6,154	1/1	C
NY[c,d]	6,069	1/3	O
NJ	5,372	1/3	O
HI	5,216	1/3	C
CA[c]	4,800	0.5/1.5	C
AK	4,707	2/4	C
RI	4,704	1/3	O
PA[c]	4,619	1.2/3.6	O
AZ	4,237	1/1	C
OR	4,234	1/3	O
MD[c,d]	4,179	1/3	O
DC[d]	3,916	1/3	O
CT[d]	3,649	1/3	O
WV[d]	3,620	1/3	O
NV	3,584	0.5/1.5	C
WI	3,492	[e]/[f]	O
ND	3,395	1/1	C
ID[d]	3,355	1/3	O
NH	3,311	1/3	O
IA	3,268	1/1	C
WA	3,203	1/3	O
GA	3,134	1/1	C
AL[d]	2,876	1/1	O
WY	2,869	1/1	O
KS	2,862	3.2/6.6	C
MO	2,858	1/1	O
ME	2,858	1/3	C
SD	2,780	1/1	C
VA[c]	2,723	1/1	C
DE[d]	2,545	1/3	C
TN	2,453	1/3	C
KY[d]	2,332	1.2/1.6	O
VT	2,293	1/1	C
LA	2,236	1/2	O
MN	2,055	1/3	C
UT[d]	2,015	1/3	O
MT	2,008	0.5/1.5	C

State	Premium	Coverage limits[a]	Policy form[b]
OK	$1,892	$5/$5	O
NC	1,891	1/1	C
OH	1,852	2.2/2.6	O
MA[d,e]	1,844	1/3	O
MS[d]	1,802	1/1	C
CO	1,760	1/1	O
NE	1,711	1/[f]	C
NM	1,704	0.5/[f]	O
TX[c]	1,437	1/1	O
SC	1,332	[f]/[f]	O
AR	1,323	1/1	C
IN	1,293	0.5/[f]	O

[a] Coverage limits are per occurrence/in aggregate. Figures are in millions.

[b] O = occurrence; C = claims-made.

[c] Leading insurer has multiple-rating territories. Premium shown is for territory with the largest number of physicians of this specialty.

[d] Leading insurer offers both occurrence and claims-made policy forms.

[e] Premium shown is conditional upon final approval of state insurance department.

[f] None.

Table 2.9: Malpractice Insurance Premiums Paid by Physicians in Neurosurgery by State as of July 1, 1985

State	Premium	Coverage limits[a]	Policy form[b]
FL[c]	$64,696	$1/$1	C
IL[c]	56,088	1/3	O
DC[d]	54,523	5/5	C
ND	41,630	1/3	C
AZ	41,623	3/3	C
NY[c,d]	37,736	1/3	O
HI	37,652	1/3	C
IA	37,270	1/1	C
WI	37,217	[f]/[f]	O
GA	35,587	1/1	C
MI[c]	34,410	1/1	O
WA	33,397	5/7	O
ID[d]	33,056	1/3	O
OR	32,994	1/3	O
CT[d]	32,901	1/3	O
MO	32,480	1/1	O
SD	31,764	1/1	C
VA[c]	30,418[g]	1/1	C
NJ	30,122	1/3	O
KY[d]	29,617	1.2/1.6	O
NH	27,676	1/3	O
WV[d]	27,622	1/3	O
MD[c,d]	27,409	1/3	O
KS	25,761	3.2/6.6	C
ME	25,305	1/3	C
CA[c]	24,248	0.5/1.5	C
RI	23,521	1/3	O
NE	23,402	1/1	C
VT	23,069	1/1	C
NV	22,592	0.5/1.5	C
DE[d]	21,489	1/3	C
MS[d]	21,021	1/1	C
PA[c]	20,196	1.2/3.6	O
MN	19,196	1/3	C
UT[d]	18,691	1/3	O
NC	18,595	1/1	C
WY	18,343	1/1	O
CO	18,136	1/1	O
LA	17,992	1/2	O

State	Premium	Coverage limits[a]	Policy form[b]
TN	$17,[illegible]23	$1/$3	C
AL[d]	17,[illegible]52	1/1	C
OH	17,443	2.2/2.6	O
MA[d],[e]	15,322	1/3	O
AR	12,612	1/1	C
TX[c]	11,609	1/1	O
MT	11,540	0.5/1.5	C
IN	11,380	0.5/[f]	O
OK	10,953	5/5	O
NM	10,627	0.5/[f]	O
SC	9,150	[f]/[f]	O
AK[h]	•	•	•

[a] Coverage limits are per occurrence/in aggregate. Figures are in millions.

[b] O = occurrence; C = claims-made.

[c] Leading insurer has multiple-rating territories. Premium shown is for territory with the largest number of physicians of this specialty.

[d] Leading insurer offers both occurrence and claims-made policy forms.

[e] Premium shown is conditional upon final approval of state insurance department.

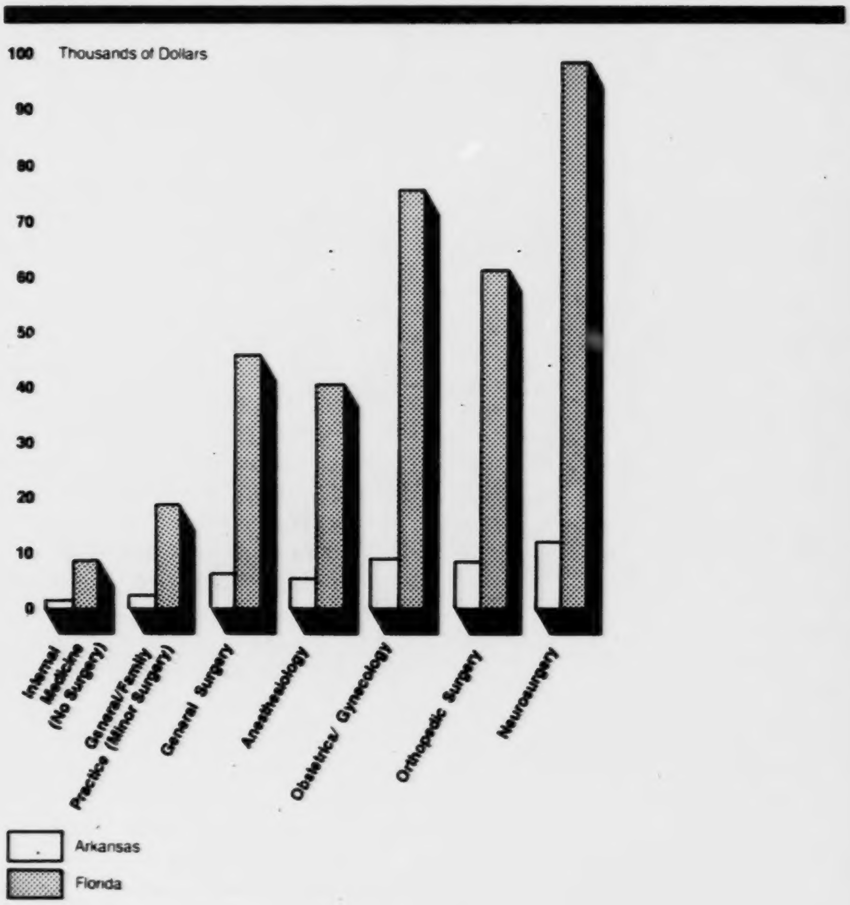
[f] None.

[g] Two territories had an equal number of physicians of this specialty. The premium for the other territory was $20,673.

[h] The leading insurer did not insure any neurosurgeons as of July 1, 1985.

Malpractice insurance premiums varied widely by state and specialty for the same coverage limits. Figure 2.2 shows the highest and lowest premiums for each of the seven specialties for a $1 million/$1 million claims-made policy. The lowest premiums in each case for this coverage limit were in Arkansas; they ranged from $1,323 for internal medicine to $12,612 for neurosurgery. The highest premiums in each case were in Florida; they ranged from $9,228 for internal medicine to $97,010 for neurosurgery.

Figure 2.2: Premium Range for a $1 Million/$1 Million Claims-Made Policy as of July 1, 1985



Wide Divergence of Physician Premiums Within Certain States

In 41 states and the District of Columbia, premium rates typically apply to all physicians in a specialty in the entire state. In nine states,[9] however, the leading insurers have multiple-rating territories. As a result, physicians in each specialty with the same coverage limits and the same form of policy pay more or less depending on the location of their practice (see apps. IV and V for malpractice insurance premiums in each of these nine states).

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[9] The states with multiple-rating territories are California, Florida, Illinois, Maryland, Michigan, New York, Pennsylvania, Texas, and Virginia (see app. III).

Premiums varied significantly among these rating territories. Generally, the higher premiums in the states with more than one rating territory were in the more urbanized areas. This is consistent with a 1982 study on the frequency and severity of medical malpractice claims, which showed that urban courts tend to award higher verdicts and that these verdicts act as an inducement for an increasing number of claims. The study concluded that urbanization is the most significant and powerful predictor of claims frequency.[10]

Typically, rating territories are developed on the basis of an insurance company's historical claims and loss experience. The analysis of this information identifies the relative or perceived risks in one area over another and serves to justify a company's filings with the state's insurance department for different rate offerings within a state. For example, the rates we obtained for Pennsylvania and Indiana were from the same insurer; however, according to this insurer, the metropolitan area of Philadelphia and surrounding counties has a historically different claims experience than the rest of Pennsylvania; as a result, the insurer has four rating territories there. In Indiana, the claims pattern for Indianapolis varies little from the rest of the state; as a result, the insurer offers one rate for the entire state.

The examples below show the high and low 1985 rates for the specialty of obstetrics/gynecology in each of five states. Other specialties followed a similar pattern.

- In Michigan, the rate for territory 1, which includes Macomb, Oakland, and Wayne Counties, was 52 percent higher than that for territory 2 (the rest of the state)—$30,198 versus $19,931. Territory 2 had slightly more obstetricians/gynecologists than territory 1.
- In Illinois, the rate for territory 1, which covers Chicago and East St. Louis, was $42,184. In the other two rating territories, it was $25,496 and $33,840. Territory 1 contains about 90 percent of the obstetricians/gynecologists insured by the leading insurer.
- In Florida, the rate in territory 1, which includes the Miami area, was 50 percent higher than that for territory 2 (the rest of the state)—$76,641 versus $51,112. Territory 1 had fewer obstetricians/gynecologists than the rest of the state.

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[10] Patricia Munch Danzon, "The Frequency and Severity of Medical Malpractice Claims," Rand, R-2870-ICJ/HCFA, Santa Monica, CA, 1982, p. 36.

- In New York[11], the rate in territory 1, which includes Long Island, was from 14 to 121 percent higher than in the other three rating territories—$68,116 versus $59,547, $52,709, and $30,818. About 7 percent of the obstetricians/gynecologists insured by the leading insurer would have paid the highest rate.
- In Pennsylvania, the rate in territory 1, which includes Philadelphia, was 97 to 206 percent higher than in the three other territories—$41,570 versus $21,068, $20,196, and $13,551. Territory 1 had less than 10 percent of the obstetricians/gynecologists being insured by the leading insurer.

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[11] In New York, the leading insurer offers both claims-made and occurrence policies. However, most obstetricians/ gynecologists purchased the occurrence form of coverage.

Chapter 3

Hospital Medical Malpractice Insurance Costs Increased From 1983 to 1985 but Varied by Region and Size of Institution

From 1983 to 1985, the percentage increase in the cost of malpractice insurance as a hospital expense item was much greater than the percentage increase in total hospital expenses. Total estimated[1] malpractice insurance costs for community hospitals in the 50 states and the District of Columbia increased by about 57 percent from about $849 million in policy year 1983 to $1,336 million in policy year 1985. On an inpatient day basis, average malpractice insurance costs increased about 85 percent—from $3.02 to $5.60—over the same period. According to AHA, from 1983 to 1985, total expenses increased about 12 percent—from $120 billion to $134 billion—while average expenses per inpatient day increased by about 26 percent—from $392 to $494. Average net revenue per inpatient day also increased about 26 percent—from $395 to $501. Despite substantial increases in average malpractice insurance costs per inpatient day, such costs still accounted for only about 1 percent of the average expense per inpatient day.

Costs of malpractice insurance and the rate of increase in these costs varied by size and regional location of the hospital. Malpractice insurance costs generally followed size of hospital; the hospitals with the fewest beds also had the lowest malpractice insurance costs per inpatient day. However, about 52 percent of the hospitals that experienced cost increases of 200 percent or more from 1983 to 1985 had fewer than 100 beds. Hospitals in the Pacific region (Alaska, California, Hawaii, Oregon, and Washington) had the highest average malpractice insurance cost per inpatient day but experienced the lowest percentage increase from 1983 to 1985.

At the time of our survey in the summer of 1985, some hospitals were also able to provide information on the cost of malpractice insurance for policy year 1986. Information provided by these hospitals indicates that their malpractice insurance costs will increase substantially in 1986.

Total Malpractice Insurance Costs and Increases Varied Widely Among Hospitals Nationwide

As shown in table 3.1, all types of hospital malpractice insurance expenditures—contributions to self-insurance trust funds, premiums for purchased insurance, and uninsured losses—increased from 1983 to 1985.

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[1] Unless otherwise indicated, the estimates presented in this chapter are also included with sampling errors in tables VIII.1 through VIII.8.

Table 3.1: Estimated Hospital Malpractice Insurance Costs by Type of Expenditure

Dollars in millions

				1983-85 increase[a]	
Expenditure	**1983**	**1984**	**1985**	**Amount**	**Percent**
Total	**$849.4**	**$959.8**	**$1,336.0**	**$486.6**	**57**
Contributions to self-insurance trust funds	255.8	289.3	350.6	94.8	37
Premiums for purchased insurance	562.4	628.2	866.8	304.4	54
Uninsured losses	31.1	42.2	118.6[b]	87.5[b]	281[b]

[a] Sampling errors for the amount and percentage of increase are not presented in appendix VIII, but they are comparable to the errors for the estimated costs.

[b] Estimates are subject to a large sampling error and should be used with caution.

Note: Details may not add to total due to independent estimation.

On an individual basis, annual hospital malpractice insurance costs ranged from less than $10,000 to over $1 million. As shown in table 3.2, there was a general increase in the annual malpractice insurance costs of hospitals between 1983 and 1985. In 1985, 56 percent of hospitals had annual malpractice insurance costs of less than $100,000, compared to 65 percent in 1983. The number of hospitals with annual costs of $1 million and over more than doubled between 1983 and 1985.

Table 3.2: Estimated Distribution of Annual Malpractice Insurance Costs for Hospitals

	Hospitals					
	1983			1985		
Annual costs	**Number**	**Percent**	**Cumulative percent**	**Number**	**Percent**	**Cumulative percent**
Less than $10,000	772	14	14	509	9	9
$10,000 to $24,999	1,047	19	33	905	16	25
$25,000 to $49,999	937	17	50	962	17	42
$50,000 to $99,999	827	15	65	792	14	56
$100,000 to $249,999	1,047	19	84	1,188	21	77
$250,000 to $499,999	441	8	92	622	11	88
$500,000 to $999,999	276	5	97	396	7	95
$1 million or more	110	2	99[a]	283	5	100
Total	**5,457**	**99[a]**		**5,657**	**100**	

[a] Does not total to 100 percent due to rounding.

Note: The total number of hospitals each year is based on the number of responding hospitals that provided the relevant data for that year.

The following examples illustrate the increases that individual hospitals experienced in their total malpractice insurance costs.

- A hospital in region 1 purchased $11 million of coverage for $21,000 in 1983. In 1985 the hospital paid $57,000, or about 171 percent more, for the same coverage.
- A hospital in region 2 in 1983 purchased $1 million of coverage for $63,000. In 1985 the hospital paid $164,000 for the same coverage, an increase of about 160 percent.
- Another hospital in region 2 in 1983 paid $700,000 for $2 million of coverage. In 1985 the hospital paid $2.35 million for the same limits, an increase of about 236 percent.
- A hospital in region 6 purchased $2 million of coverage for $17,000 in 1983 but paid $65,000 for the same coverage in 1985, an increase of about 282 percent.

Average Malpractice Insurance Costs Per Inpatient Day and Per Bed Increased Significantly From 1983 to 1985

Two means of measuring the relative impact of medical malpractice insurance costs on hospitals are by the number of inpatient days and the number of beds. As shown in table 3.3, from 1983 to 1985 the average malpractice insurance cost per inpatient day increased by about 85 percent, while the average annual malpractice insurance cost per bed[2] increased by about 78 percent.

Table 3.3: Estimated Average Hospital Malpractice Insurance Costs Per Inpatient Day and Per Bed

				1983-85 Increase[a]	
	1983	1984	1985	Amount	Percent
Average malpractice cost per inpatient day	$3.02	$3.81	$5.60	$2.58	85
Average annual malpractice cost per bed	$1,000	$1,231	$1,784	$784	78

[a] Sampling errors for the amount and percentage of increase are not presented in appendix VIII, but they are comparable to the errors for the estimated costs.

While the average malpractice insurance cost per inpatient day increased from $3.02 in 1983 to $5.60 in 1985, the malpractice insurance cost per inpatient day was much higher for some hospitals. As shown in table 3.4, 75 percent of the hospitals in 1983 had malpractice insurance costs per inpatient day of $3 or less, while about 3 percent had malpractice insurance costs per inpatient day of more than $10. By 1985 the proportion of hospitals with malpractice insurance costs per inpatient day of $3 or less had decreased to about 49 percent, and the percentage of hospitals with malpractice insurance costs of more than $10 per inpatient day had quadrupled to 12 percent.

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[2] In determining the average annual cost per bed, we used the methodology employed by the St. Paul Insurance Company, which involves first computing the daily occupied bed rate (the total number of

Table 3.4: Estimated Distribution of Malpractice Insurance Costs Per Inpatient Day

	Hospitals								
	1983			1984			1985		
Insurance costs per day	Number	Percent	Cumulative percent	Number	Percent	Cumulative percent	Number	Percent	Cumulative percent
$ 1	1,793	34	34	1,413	26	26	778	14	14
2	1,371	26	60	1,413	26	52	1,056	19	33
3	791	15	75	815	15	67	889	16	49
4	422	8	83	543	10	77	667	12	61
5	264	5	88	326	6	83	500	9	70
6	158	3	91	272	5	88	334	6	76
7	158	3	94	163	3	91	222	4	80
8	53	1	95	109	2	93	222	4	84
9 to 10	105	2	97	163	3	96	278	5	89
11 to 20	105	2	99	163	3	99	500	9	98
Over 20	53	1	100	109	2	101[a]	167	3	101[a]
Total	**5,273**	**100**		**5,489**	**101[a]**		**5,613**	**101[a]**	

[a] Does not add to 100 percent due to rounding.

Note: The total number of hospitals each year is based on the number of responding hospitals that provided the relevant data for that year.

In addition, the changes in malpractice insurance costs per inpatient day varied widely among the hospitals. As shown in table 3.5, about 2,500 hospitals, or 46 percent, had increases in malpractice insurance costs per inpatient day of 10 to 99 percent from 1983 to 1985, while another 39 percent, or about 2,100 hospitals, had increases of 100 percent or more.

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inpatient days divided by 365) and increasing the number obtained by one bed for every 2,000 outpatient visits. This number of beds is then divided into the total annual malpractice insurance costs incurred by the hospital to produce the average annual malpractice cost per bed.

Table 3.5: Estimated Distribution of Changes in Malpractice Insurance Costs Per Inpatient Day From 1983 to 1985

	Hospitals		
Percent changes	**Number**	**Percent**	**Cumulative percent**
Increases of less than 10 or all decreases	821	15	15
+10 to 49	1,368	25	40
+50 to 99	1,149	21	61
+100 to 199	1,313	24	85
+200 to 299	438	8	93
+300 or more	383	7	100
Total	**5,472**	**100**	

Note: The total number of hospitals is based on the number of responding hospitals that provided data for both 1983 and 1985 so that the percent change could be calculated.

Hospital Malpractice Insurance Costs Varied by Region

Costs per inpatient day and increases by region varied widely. As shown in table 3.6, average malpractice insurance costs per inpatient day in 1985 ranged from $3.30 in region 7 (Arkansas, Louisiana, Oklahoma, and Texas) to $10.16 in region 9 (Alaska, California, Hawaii, Oregon, and Washington). The percentage increases from 1983 to 1985 ranged from 51 to 124 percent. Four regions had increases of over 100 percent.

Table 3.6: Estimated Average Malpractice Insurance Costs Per Inpatient Day by Region

	Insurance costs per day			1983-85 increase[b]	
Region[a]	**1983**	**1984**	**1985**	**Amount**	**Percent**
1	$2.48	$2.79	$4.31	$1.83	74
2	3.18	3.69	5.10	1.92	60
3	2.75	3.78	5.16	2.41	88
4	3.30	4.30	7.38	4.08	124
5	2.15	2.49	3.86	1.71	80
6	1.61	2.19	3.60	1.99	124
7	1.53	2.27	3.30	1.77	116
8	3.25	4.29	6.78	3.53	109
9	6.71	7.86	10.16	3.45	51

[a] See appendix I for the U.S. census regions.

[b] Sampling errors for the amount and percentage of increase are not presented in appendix VIII, but they are comparable to the errors for the estimated costs.

As shown in table 3.7, 256 of 441 (58 percent) of the hospitals in region 5 had increases in their malpractice insurance costs per inpatient day of 100 percent or more from 1983 to 1985—the largest percentage of all regions. In contrast, region 2 had the smallest percentage of hospitals with such increases—21 percent.

Table 3.7: Estimated Distribution of Changes in Malpractice Insurance Costs Per Inpatient Day From 1983 to 1985 by Region

		Percent changes in costs							
		Increases of less than 10 percent or decreases		Increases					
				10 to 49 percent		50 to 99 percent		100 percent or more	
Region[a]	Number[b] of hospitals	No.	Percent	No.	Percent	No.	Percent	No.	Percent
All hospitals[c]	**5,472**	**821**	**15**	**1,368**	**25**	**1,149**	**21**	**2,134**	**39**
1	243	46	19	68	28	51	21	78	32
2	566	142	25	209	37	96	17	119	21
3	780	148	19	172	22	164	21	289	37
4	861	95	11	215	25	207	24	327	38
5	441	93	21	62	14	31	7	256	58
6	792	63	8	142	18	206	26	380	48
7	750	128	17	165	22	165	22	285	38
8	354	32	9	103	29	74	21	145	41
9	685	75	11	212	31	151	22	240	35

[a] See appendix I for the U.S. census regions.

[b] Detail by percent change may not add to total or 100 percent due to rounding.

[c] Detail by region may not add to total for all hospitals due to independent estimation.

Note: See note to table 3.5.

Malpractice Insurance Costs Varied by Size of Hospital

The variance in average malpractice insurance costs per inpatient day generally followed the size of hospitals; the hospitals with the fewest beds had the lowest costs, and the hospitals with the most beds had the highest costs in both 1983 and 1984. However, in 1985, hospitals with 300 to 499 beds had higher costs than hospitals with 500 or more beds, and those with 100 to 199 beds had higher costs than those with 200 to 299 beds. Table 3.8 shows average malpractice insurance costs per inpatient day for 1983, 1984, and 1985 and changes from 1983 to 1985 by size of hospital.

Table 3.8: Estimated Average Malpractice Insurance Costs Per Inpatient Day by Size of Hospital

	Insurance costs per day			1983-85 increase[a]	
Hospital size (number of beds)	1983	1984	1985	Amount	Percent
Fewer than 50	$2.72	$3.29	$4.60	$1.88	69
50 to 99	2.72	3.47	5.10	2.38	88
100 to 199	2.86	3.88	5.74	2.88	101
200 to 299	3.16	3.56	5.15	1.99	63
300 to 399	3.65	4.78	8.27	4.62	127
400 to 499	3.79	5.03	7.37	3.58	94
500 or more	4.30	5.17	6.94	2.64	61

[a] Sampling errors for the amount and percentage of increase are not presented in appendix VIII, but they are comparable to the errors for the estimated costs.

As shown by table 3.9, about 21 percent of the hospitals with fewer than 50 beds experienced increases in their malpractice insurance costs per inpatient day of 200 percent or more. Of the 438 hospitals that had increases of between 200 to 299 percent, 169 (or about 38 percent) had fewer than 50 beds. Forty-five percent of the hospitals with 50 to 99 beds experienced increases in their malpractice insurance costs per inpatient day of 100 percent or more.

Table 3.9: Estimated Distribution of Changes in Malpractice Insurance Costs Per Inpatient Day From 1983 to 1985 by Size of Hospital

		Percent changes in costs									
		Increases of less than 50 percent and decreases		Increases							
				50 to 99 percent		100 to 199 percent		200 to 299 percent		300 percent or more	
Hospital size (number of beds)	Number[a] of hospitals	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
All hospitals[b]	**5,472**	**2,189**	**40**	**1,149**	**21**	**1,313**	**24**	**438**	**8**	**383**	**7**
Fewer than 50	1,127	406	36	248	22	225	20	169	15	68	6
50 to 99	1,368	451	33	287	21	424	31	68	5	123	9
100 to 199	1,304	535	41	248	19	326	25	117	9	78	6
200 to 299	707	389	55	106	15	141	20	35	5	28	4
300 to 399	412	194	47	103	25	74	18	16	4	29	7
400 to 499	255	97	38	76	30	54	21	10	4	18	7
500 or more	299	120	40	78	26	69	23	15	5	18	6

[a] Detail by percent change may not add to total or 100 percent due to rounding.

[b] Detail by bed size may not add to total for all hospitals due to independent estimation.

Note: See note to table 3.5.

Insurance Availability and Affordability Problems Foreseen by Hospitals in 1986

Our survey asked hospitals to comment on insurance problems for 1986, specifically with regard to availability and affordability. Of the 1,210 hospitals that commented on availability of insurance for 1986, about 51 percent, or 614, indicated there were or will be problems. Of the 1,208 hospitals that commented on affordability of insurance for 1986, about 56 percent, or 698, stated that affordability was or will be a problem.

Insurance Availability Problems

The most frequently cited availability problem was the reduction in the number of insurers. The 159 hospitals that responded that a reduction in insurers was a problem were generally concerned with the lack of competitiveness in the insurance market. For example, one 250-bed hospital commented that it could get only one carrier to provide a quote for its 1986 coverage with a resultant 200-percent increase in premiums for lower limits than previously carried.

The second most frequently cited problem was the limited availability of above primary or excess coverage. Typical of the responses among 106 hospitals was "difficulty in finding carrier to provide excess coverage."

In addition, many hospitals that were able to find a carrier were not able to obtain the desired limits of coverage. A total of 97 hospitals cited unavailability of the desired coverage limits as a problem in 1986. One 318-bed hospital had to reduce its excess limits from $20 million to $10 million at more than twice the cost. A 591-bed hospital advised us that it could obtain excess coverage limits of only $25 million rather than the $40 million it preferred and had to increase its primary self-insurance retention levels from $1 million/$3 million to $2 million/$5 million. Another hospital with 677 beds could obtain only one-third of its prior year's coverage limits.

Limited availability of occurrence form policies was cited by 33 hospitals. Some commented that carriers had ceased providing occurrence coverage or that they would continue providing occurrence coverage only for substantially higher premiums, thus forcing them to buy claims-made policies.

Insurance Affordability Problems

Of the 698 hospitals that had indicated affordability of insurance as a problem in 1986, 215 gave us specific information on cost increases for their 1986 coverage. Overall, the total malpractice insurance costs for these hospitals increased from $60 million in 1985 to $151 million in 1986, or about 152 percent. The cost increases in 1986 for these hospitals ranged from $1,400 to $7.1 million, while the percentage increase ranged from 4 to 1,400 percent. The median cost increase was $129,917. The amount of the increases reported by all hospitals varied depending on whether they had the same coverage as in the previous year or had changed coverage.

Of the 215 hospitals, 20 percent reported cost increases of less than 50 percent, 71 percent reported increases between 50 and 400 percent, and 9 percent reported increases greater than 400 percent. The affordability problem experienced by hospitals with cost increases of less than 50 percent can be illustrated by one hospital's experience. In this instance, the medical malpractice insurance premium cost for a 250-bed hospital was $116,000 in 1985 and increased to $142,000 for half the coverage limits in 1986. The hospital stated that this 23-percent increase in costs forces it to increase patient charges, thus further escalating the cost of health care.

Of these 215 hospitals, 143 made no change in coverage from 1985, while 72 made changes in coverage (reducing limits, adding deductibles, changing policy form, adding coverage, etc.). The cost for hospitals that kept the same coverage from 1985 to 1986 increased from $37.4 million in 1985 to $90.0 million in 1986, or by 141 percent. The median cost increase was $112,744. For example, an official of a 90-bed county hospital commented that total costs for malpractice insurance in 1985 were about $55,400, but the same coverage in 1986 cost $221,600—an increase of 300 percent. Based on the hospital's 1985 inpatient days, we determined that the malpractice insurance costs per inpatient day increased from $3.82 to $15.29. The official also indicated that the hospital had limited opportunity to pass these costs on to patients since it was under an 80-percent fixed reimbursement plan. The official indicated further that the increased cost was having a great effect on the hospital's survival.

For the 72 hospitals that changed coverage, total costs increased from $22.6 million in 1985 to $60.8 million in 1986, or by 169 percent. The median increase was $214,503. The type of coverage changes cited included changes in deductibles, limits, or policy form; establishing a self-insurance trust fund; or requirements for coverage of physicians. For example, a 149-bed hospital stated the cost of primary coverage increased from $140,261 in 1985 to $566,000 in 1986, or about 304 percent. Only one insurer quoted a rate for excess coverage of $1.5 million/$15 million coverage at a cost of $350,000. The hospital stated that due to the increase for primary insurance, it elected not to purchase excess insurance in 1986. In another case, a 354-bed hospital reported that 1986 costs for primary insurance increased by 28 percent and for excess insurance by 628 percent, even though they switched to a claims-made policy.

Three hospitals reported cost increases of over 1,000 percent even with coverage changes. In one case, a 929-bed hospital reported a 1,400-percent increase (from $53,000 to $795,000) in its premiums for a policy with $25 million excess coverage limits compared to $60 million excess coverage limits in 1985. In addition, the hospital had to make a 100-percent increase in its primary self-insurance levels from $5 million/$10 million to $10 million/$20 million.

In another case, a 1,041-bed hospital reported the cost of $50 million excess coverage limits in 1985 was $105,000, but the cost for this same level of coverage in 1986 was about $1.6 million, representing a

1,400-percent increase. The hospital also had to increase its primary self-insurance levels from $3 million/$5 million to $8 million/ $10 million.

In the third case, a 30-bed hospital with combined coverage limits of $2 million/$6 million paid about $17,000 in premiums in 1985 for a claims-made policy and had to pay $240,000 in 1986 for occurrence coverage—an increase of over 1,300 percent. The hospital administrator stated that only one insurance company was writing hospital malpractice coverage for 1986 in this state.

Chapter 4

Many Hospitals Increased Total Coverage Limits While Inpatient Days Decreased

From the beginning of policy year 1983 to the beginning of policy year 1985, about 1,920 hospitals increased their total per-occurrence limits of malpractice insurance coverage. The increased coverage limits, coupled with cost increases related to changes in overall insurance market conditions, resulted in increased total hospital malpractice insurance costs. During the same period, total estimated[1] inpatient days, a revenue base for recovering these costs, decreased about 13 percent, from 267 million to 232 million. Hospitals with fewer than 300 beds experienced the greatest percentage decreases in total inpatient days.

Some hospitals responding to our survey commented that, as insurance costs were increasing, the revenue base over which these costs could be spread was decreasing as inpatient days decreased and new cost containment regulations or eligibility restrictions were initiated by the states and the federal government. This put them in a "squeeze" situation in which they were not able either to absorb the malpractice insurance increases without adverse effects on operations or to pass on the increases to patients or other purchasers.

About 1,050 hospitals made changes to their insurance programs that would tend to reduce cost, or at least minimize cost increases. These changes were (1) establishing a self-insurance trust fund to cover all or part of the malpractice risk, (2) switching from the generally more expensive occurrence policy to the claims-made policy, (3) adding or increasing a deductible, and (4) contrary to the overall trend, decreasing total per-occurrence coverage limits. Further actions by hospitals, such as establishing or improving programs designed to reduce claims by reducing the incidence of malpractice, would also influence malpractice costs. However, information on the extent or effect of such programs was not part of our review.

Inpatient Days Decreased

About 84 percent of the hospitals experienced decreases in inpatient days between 1983 and 1985. While the total number of inpatient days decreased by about 13 percent, the decreases for many hospitals were much greater. For example, about 1,930 hospitals experienced inpatient day decreases from 20 to 39 percent, while about 520 hospitals expressed decreases of 40 or more percent.

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[1] Unless otherwise indicated, the estimates presented in this chapter are also included with sampling errors in tables VIII.9 through VIII.16.

Although hospitals in all regions and of all sizes experienced decreases in inpatient days from 1983 to 1985, the extent of the decreases varied widely. As shown in table 4.1, the regional decreases ranged from about 1.4 million inpatient days in region 1 to 8.6 million in region 4. In terms of percentages, region 6 had the largest decrease in inpatient days, about 20 percent.

Table 4.1: Estimated Number of Inpatient Days by Region

Inpatient days in millions

	Inpatient days			1983-85 change[b]	
Region[a]	**1983**	**1984**	**1985**	**Number**	**Percent**
All hospitals	**267.1**	**251.1**	**232.1**	**−35.0**	**−13**
1	14.1	13.4	12.7	−1.4	−10
2	50.7	49.6	47.1	−3.6	−7
3	43.6	40.7	37.9	−5.7	−13
4	51.0	47.2	42.4	−8.6	−17
5	19.7	18.6	16.8	−2.9	−15
6	23.4	20.9	18.8	−4.6	−20
7	27.6	26.1	23.5	−4.1	−15
8	10.1	9.4	8.6	−1.5	−15
9	26.9	25.2	24.3	−2.6	−10

[a] See appendix I for the U.S. census regions.

[b] Sampling errors for the number and percentage of change are not presented in appendix VIII, but they are comparable to the errors for the estimated inpatient days.

Note: Detail by region may not add to total for all hospitals due to independent estimation.

As shown in table 4.2, hospitals with 100 to 199 beds experienced the greatest decrease in the number of inpatient days from 1983 to 1985. In terms of percentages, decreases in inpatient days were generally inversely proportional to size, with the smallest hospitals having the largest percent decreases.

Table 4.2: Estimated Number of Inpatient Days by Size of Hospital

Inpatient days in millions

	Inpatient days			1983-85 change[a]	
Hospital size (number of beds)	**1983**	**1984**	**1985**	**Number**	**Percent**
All hospitals	**267.1**	**251.1**	**232.1**	**−35.0**	**−13**
Fewer than 50	7.5	7.0	5.9	−1.6	−21
50 to 99	22.3	20.4	18.4	−3.9	−17
100 to 199	48.1	43.9	40.3	−7.8	−16
200 to 299	47.7	44.6	40.7	−7.0	−15
300 to 399	40.9	38.8	36.1	−4.8	−12
400 to 499	32.7	30.9	28.8	−3.9	−12
500 or more	67.8	65.5	61.9	−5.9	−9

[a] Sampling errors for the number and percentage of change are not presented in appendix VIII, but they are comparable to the errors for the estimated inpatient days.

Note: Detail by hospital size may not add to total for all hospitals due to independent estimation.

Many Hospitals Increased Limits of Coverage

One factor that influences the cost of insurance is the level of coverage carried by hospitals—the higher the limits, the higher the cost. About 1,920 of the hospitals increased their total per-occurrence limits from the beginning of policy year 1983 to the beginning of policy year 1985, while about 3,210 hospitals had no change and about 460 decreased their total per-occurrence limits.

When analyzed by source of coverage,[2] as shown in table 4.3, hospitals using a combination of purchased insurance with a self-insurance trust fund (combination coverage) had considerably higher limits than hospitals using only a self-insurance trust fund or only purchased insurance. From 1983 to 1985 the median per-occurrence limits increased nationally and in most regions for both purchased and combination coverage. The greatest increases in median coverage amounts, however, occurred in regions 1, 2, and 6 among hospitals using the combination coverage. As shown in table 4.3, median limits in region 1 among hospitals using combination coverage rose from $10.5 million to $20.2 million. In region 6, limits among hospitals using this source of coverage quadrupled, rising from $5.2 million to $22.0 million.

In region 8, contrary to the general pattern, combination coverage limits decreased dramatically from $51.0 million to $11.0 million. This decrease was due primarily to changes in coverage made by one multihospital system in the region.

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[2] About 240 hospitals with unlimited per-occurrence limits were excluded from our analysis because the unlimited designation has no specific figure assigned to it that can be used in computing median limits or changes in limits.

Table 4.3: Estimated Median Per-Occurrence Coverage Limits by Source of Coverage by Region

Dollars in millions

	Median coverage limits					
	Self-insurance trust fund only		Purchased only		Combination of purchased and self-insurance	
Region[a]	**1983**	**1985**	**1983**	**1985**	**1983**	**1985**
All hospitals	**$1.0**	**$1.0**	**$2.0**	**$3.0**	**$10.9**	**$12.0**
1	[b]	[b]	5.2	6.0	10.5	20.2
2	2.8	3.4	3.0	3.2	11.1	16.0
3	1.5	1.5	2.0	3.0	10.2	10.2
4	1.0	1.0	1.3	2.2	20.0	23.0
5	1.0	1.0	1.3	2.0	20.0	22.0
6	1.0	1.0	2.0	3.0	5.2	22.0
7	3.0	3.0	1.0	2.0	4.6	4.6
8	0.5	1.0	4.0	6.0	51.0	11.0
9	1.0	1.0	10.0	10.0	8.0	10.0

[a] See appendix I for the U.S. census regions.

[b] No hospitals with self-insurance trust fund only coverage.

Median per-occurrence limits of hospitals of most sizes using purchased insurance or combination coverage increased. The greatest increases occurred among hospitals using combination coverage. Median limits of hospitals with fewer than 50 beds using the combination coverage increased from $5.2 million to $11 million between 1983 and 1985, while median limits of hospitals with 50 to 99 beds increased from $4.6 million to $10.2 million.

Hospitals Changed Source of Coverage

Source of coverage also influences a hospital's total malpractice insurance costs. Hospitals were generally changing to more expensive sources. Overall, the major change was the increase from 1983 to 1985 in the number of hospitals using combination coverage. Further, fewer hospitals were going without coverage. In 1985, 103 hospitals went without coverage compared to 120 in 1983. As shown in table 4.3, the combination coverage has the highest per-occurrence limits, and thus the highest costs.

Hospitals in most regions were changing their source of coverage. Most of the activity was in regions 3, 4, and 5. As shown in table 4.4, regions

4 and 5 had large changes in the use of self-insurance between 1983 and 1985, but these changes were in opposite directions. In region 4, 83 hospitals were self-insured in 1983 compared to only 36 in 1985—a decrease of about 57 percent. Most of this change appeared to account for the increase in the use of combination coverage.

In region 5, 51 more hospitals self-insured in 1985 than in 1983. This increase in the use of self-insurance appeared to have resulted from the decrease in the use of purchased insurance. For example, a 147-bed hospital that purchased per-occurrence limits of $100,000 paid about $38,000 in 1983 and $47,000 in 1984. This hospital replaced the purchased coverage in 1985 with a self-insurance trust fund having limits of $500,000. The hospital made a contribution to its trust fund of about $20,000 in 1985. A hospital official indicated he believed the hospital could control affordability by using self-insurance.

Table 4.4: Estimated Distribution of Sources of Insurance Coverage by Region

	Hospitals								
	Self-insurance trust fund only			Purchased only			Combination of purchased and self-insurance		
Region[a]	1983	1985	Change[b]	1983	1985	Change[b]	1983	1985	Change[b]
All hospitals	**319**	**327**	**+8**	**4,324**	**4,219**	**−105**	**929**	**1,083**	**+154**
1	[c]	[c]	•	229	224	−5	20	25	+5
2	10	5[d]	−5[d]	480	488	+8	77	75	−2
3	72	72	•	513	485	−28	214	245	+31
4	83	36	−47	632	649	+17	180	213	+33
5	61	112	+51	378	322	−56	29	37	+8
6	28[d]	28[d]	•	685	685	•	55	55	•
7	26	26	•	637	625	−12	102	158	+56
8	20	20	•	238	232	−6	100	106	+6
9	21	25	+4	532	507	−25	151	168	+17

[a] See appendix I for the U.S. census regions.

[b] The changes may reflect only the amount of the sampling errors for the estimated distribution.

[c] No hospitals with self-insurance trust fund only coverage.

[d] Estimates subject to a large sampling error and should be used with caution.

Note: Detail by region may not add to total for all hospitals due to independent estimation.

Between 1983 and 1985, more hospitals with fewer than 200 beds than hospitals with 200 or more beds changed their source of malpractice insurance coverage. As indicated in table 4.5, of the hospitals with fewer than 50 beds, 49 fewer hospitals used purchased insurance in 1985 than had used this source in 1983. For example, one hospital with 24 beds changed from purchased insurance with $1 million per-occurrence total limits that cost $7,600 in 1983 to self-insurance for the same limits at a cost of $5,400 in 1985. For hospitals with 50 to 99 beds, 47 fewer hospitals were using purchased insurance in 1985 than in 1983. At the same time, however, 45 more hospitals of this size were using combination coverage.

Table 4.5: Estimated Distribution of Sources of Insurance Coverage by Size of Hospital

	Hospitals								
	Self-insurance trust fund only			Purchased only			Combination of purchased and self-insurance		
Hospital size (number of beds)	1983	1985	Change[a]	1983	1985	Change[a]	1983	1985	Change[a]
All hospitals	**319**	**327**	**+8**	**4,324**	**4,219**	**−105**	**929**	**1,083**	**+154**
Fewer than 50	42	87	+45	996	947	−49	110	142	+32
50 to 99	94	94	•	1,203	1,156	−47	97	142	+45
100 to 199	88	69	−19	1,004	989	−15	237	292	+55
200 to 299	27	23	−4	546	551	+5	140	138	−2
300 to 399	21	18	−3	264	260	−4	136	143	+7
400 to 499	21	13	−8	149	154	+5	90	91	+1
500 or more	27	22	−5	163	161	−2	120	131	+11

[a] The changes may reflect only the amount of the sampling errors for the estimated distribution.

Note: Detail by hospital size may not add to total for all hospitals due to independent estimation.

Other Actions

During the 1983-85 period, about 18 percent (or 1,050) of the hospitals made one or more changes to their insurance programs that could tend to reduce cost, or at least minimize cost increases. These changes included (1) decreasing total per-occurrence limits, (2) switching from the occurrence policy form to claims-made policies, (3) establishing self-insurance trust funds to cover all or part of the malpractice exposure, and (4) adding a deductible provision or increasing the deductible limits.

The most frequent change made by the hospitals was to decrease total per-occurrence limits. As mentioned, about 460 hospitals decreased their limits. Of these, about 400 made no other cost-minimizing change, while the others decreased coverage limits in addition to establishing self-insurance trust funds, adding or increasing deductibles, and/or switching to claims-made policies.

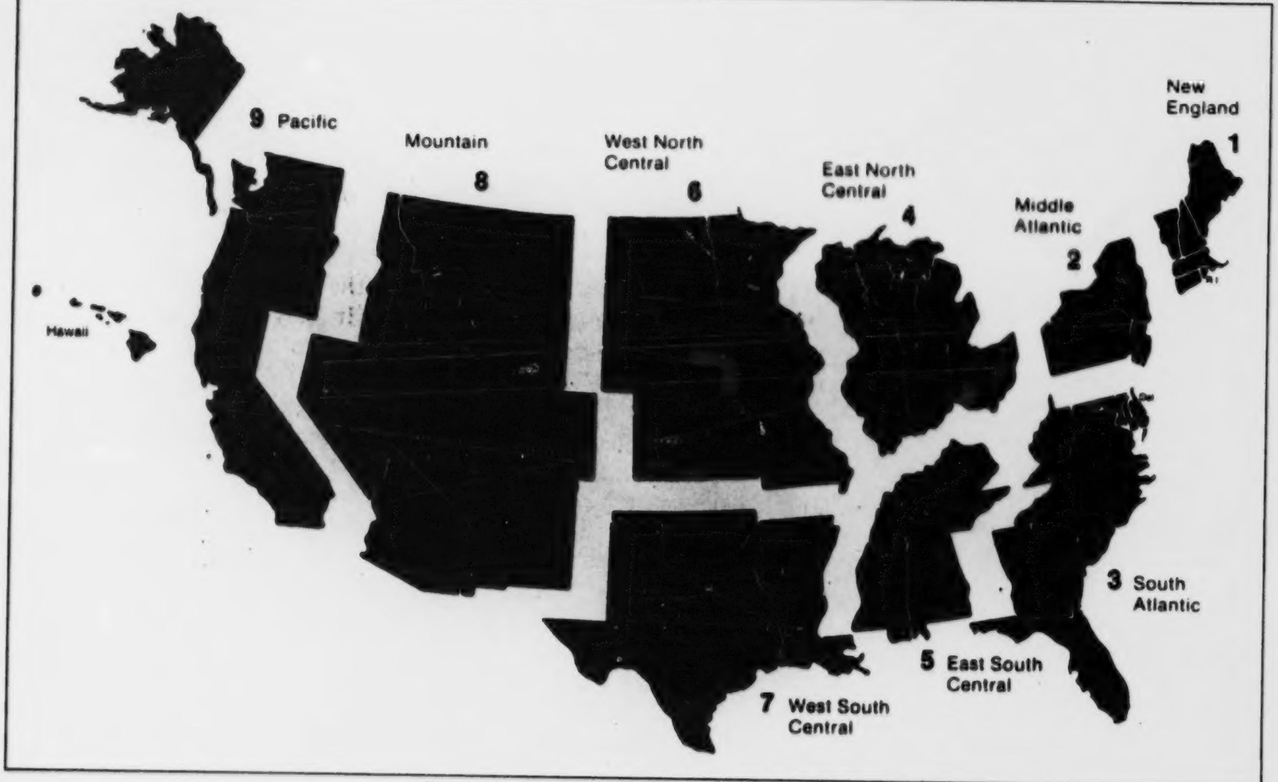
The second most frequent change was to switch from a generally more expensive occurrence policy to a claims-made policy. About 230 hospitals made this change. At the same time, about 90 of these were increasing their per-occurrence limits. Another 25 were decreasing coverage limits, adding self-insurance trust funds, and/or adding or increasing deductibles.

Another change was the establishment of self-insurance trust funds. Overall about 210 hospitals added trust funds either as their only cost-minimizing action or in combination with changing coverage limits and/or switching to claims-made policies. As shown, the net increase in the use of self-insurance trust funds either alone or in combination with purchased insurance was 162 hospitals.

The other change—adding a deductible provision or increasing the deductible limits—also was made by about 210 hospitals. Of these hospitals, 135 were also changing coverage limits and 10 were switching to claims-made policies. The median per-occurrence deductible limit increased from $5,000 for about 1,000 hospitals with a deductible provision in 1983 to $10,000 for about 1,100 hospitals in 1985.

Appendix I

U.S. Census Regions


New England
1
9 Pacific
Mountain
8
West North Central
6
East North Central
4
Middle Atlantic
2
Hawaii
3 South Atlantic
5 East South Central
7 West South Central

Source: Hospital Statistics, 1983 Edition, American Hospital Association.

Insurance Premiums for Predominately Purchased Coverage Limits and Policy Form by State for Five Specialties

This appendix contains five tables that provide the insurance premiums by state for predominately purchased coverage limits and policy form for five physician specialties as of July 1, 1985.

Coverage limits are in millions of dollars. States with coverage limits of "none" have state funds (such as a patient compensation fund) that provide unlimited coverage for physicians participating in the funds, even though Indiana, Nebraska, and New Mexico place limits on amounts paid for individual incidents.

In 11 states and the District of Columbia, the leading insurer offers both occurrence and claims-made policy forms. In those cases, the premiums shown are for the policy form purchased most often by physicians of each particular specialty.

In nine states, the leading insurer has multiple-rating territories. Premiums shown are for the territory with the largest number of physicians of each specialty.

Table II.1: Malpractice Insurance Premiums Paid by Physicians in General/Family Practice (Minor Surgery) **by State as of July 1, 1985**

State	Premium	Coverage limits[a]	Policy form[b]
FL[c]	$12,156	$1/$1	C
IL[c]	11,592	1/3	O
HI	10,136	1/3	C
ME	8,656	1/3	C
RI	8,467	1/3	O
CA[c]	8,124	0.5/1.5	C
NY[c,d]	8,088	1/3	O
AK	7,780	2/4	C
WI	6,902	[e]/[e]	O
ND	6,658	1/1	C
IA	6,392	1/1	C
CT[d]	6,386	1/3	O
WV[d]	6,297	1/3	O
GA	6,118	1/1	C
OR	5,998	1/3	O
NH	5,959	1/3	O
MD[c,d]	5,743	1/3	O
AZ	5,650	1/1	C
WA	5,466	1/3	O
SD	5,445	1/1	C
KS	5,296	3.2/6.6	C
MO	5,143	1/1	O
ID[d]	5,112	1/3	O
KY[d]	5,013	1.2/1.6	O
WY	4,985	1/1	O
AL[d]	4,905	1/1	O
MI[c]	4,779	0.2/0.6	O
TN	4,724	1/3	C
MN	4,721	1/3	C
NV	4,664	0.5/1.5	C
VT	4,423	1/1	C
PA[c]	4,264	1.2/3.6	O
VA[c]	4,214	1/1	C
NJ	4,186	1/3	O
DE[d]	4,072	1/3	C
NE	4,057	1/1	C
DC[d]	3,916	1/3	O
UT[d]	3,909	1/3	O
LA	3,853	1/2	O

State	Premium	Coverage limits[a]	Policy form[b]
OH	$3,837	$2.2/$2.6	O
MS[d]	3,604	1/1	C
CO	3,444	1/1	O
MA[d],[e]	2,950	1/3	O
NM	2,917	0.5/[f]	O
NC	2,760	1/1	C
AR	2,494	1/1	C
MT	2,476	0.5/1.5	C
IN	2,328	0.5/[f]	O
SC	2,203	[f]/[f]	O
TX[c]	2,156	1/1	O
OK	2,120	1/1	O

[a] Coverage limits are per occurrence/in aggregate. Figures are in millions.

[b] O = occurrence; C = claims-made.

[c] Leading insurer has multiple-rating territories. Premium shown is for territory with the largest number of physicians of this specialty.

[d] Leading insurer offers both occurrence and claims-made policy forms.

[e] Premium shown is conditional upon final approval of state insurance department.

[f] None.

Table II.2: Malpractice Insurance Premiums Paid by Physicians in General Surgery by State as of July 1, 1985

State	Premium	Coverage limits[a]	Policy form[b]
FL[c]	$30,736	$1/$1	C
IL[c]	28,280	1/3	O
CA[c]	23,172	0.5/1.5	C
CT[d]	20,563	1/3	O
MO	20,138	1/1	O
MD[c,d]	19,719	1/3	O
MI[c]	19,704	0.2/0.6	O
NV	19,192	0.5/1.5	C
HI	19,116	1/3	C
RI	18,817	1/3	O
ND	18,610	1/1	C
NJ	18,210	1/3	O
DC[d]	18,171	1/3	C
NY[c,d]	18,107	1/3	O
AZ	17,954	1/1	C
IA	17,834	1/1	C
KS	17,747	3.2/6.6	C
WI	17,302	[f]/[f]	O
NH	17,297	1/3	O
WV[d]	17,264	1/3	O
OR	17,228	1/3	O
GA	17,035	1/1	C
KY[d]	16,765	1.2/1.6	O
WA	16,135	1/3	O
SD	15,194	1/1	C
ID[d]	15,029	1/3	O
AK	14,802	2/4	C
WY	14,667	1/1	O
PA[c]	14,586	1.2/3.6	O
ME	14,205	1/3	C
DE[d]	13,431	1/3	C
AL[d]	12,706	1/1	C
MN	12,648	1/3	C
MS[d]	12,012	1/1	C
TN	11,963	1/3	C
VA[c]	11,667	1/1	C
VT	11,024	1/1	C
CO	10,872	1/1	O
OH	10,705	2.2/2.6	O

State	Premium	Coverage limits[a]	Policy form[b]
LA	$10,350	$1/$2	O
MT	9,808	0.5/1.5	C
MA[d,e]	9,577	1/3	O
NC	8,896	1/1	C
OK	8,772	5/5	O
UT[d]	8,581	1/3	O
NM	8,516	0.5/[f]	O
NE	8,097	1/[f]	C
TX[c]	8,036	1/1	O
IN	7,760	0.5/[f]	O
AR	6,063	1/1	C
SC	5,809	[f]/[f]	O

[a] Coverage limits are per occurrence/in aggregate. Figures are in millions.

[b] O = occurrence; C = claims-made.

[c] Leading insurer has multiple-rating territories. Premium shown is for territory with the largest number of physicians of this specialty.

[d] Leading insurer offers both occurrence and claims-made policy forms.

[e] Premium shown is conditional upon final approval of state insurance department.

[f] None.

Table II.3: Malpractice Insurance Premiums Paid by Physicians in Anesthesiology by State as of July 1, 1985

State	Premium	Coverage limits[a]	Policy form[b]
AZ	$35,232	$3/$3	C
DC[d]	28,695	5/5	C
IL[c]	28,280	1/3	O
HI	28,092	1/3	C
FL[c]	27,339	1/1	C
RI	23,521	1/3	O
CT[d]	23,236	1/3	O
AK	22,264	2/4	C
WA	20,975	5/7	O
WV[d]	20,717	1/3	O
MO	20,138	1/1	O
ND	18,610	1/1	C
WY	18,343	1/1	O
ID[d]	18,027	1/3	O
MS[d]	18,018	5/5	C
MD[c,d]	17,970	1/3	O
TN	17,885	5/7	C
IA	17,834	1/1	C
KS	17,747	3.2/6.6	C
KY[d]	17,316	1.2/1.6	O
WI	17,302	[f]/[f]	O
NH	17,297	1/3	O
OR	17,228	1/3	O
GA	17,035	1/1	C
CA[c]	16,620	0.5/1.5	C
MI[c]	16,496	1/1	O
OH	15,885	2.2/2.6	O
CO	15,272	1/1	O
SD	15,194	1/1	C
AL[d]	15,179	1/1	C
PA[c]	14,586	1.2/3.6	O
ME	14,205	1/3	C
NJ	13,817	1/3	O
DE[d]	13,431	1/3	C
NV	13,148	0.5/1.5	C
LA	12,924	1/2	O
NY[c,d]	11,928	1/3	O
NE	11,228	1/1	C
OK	10,953	5/5	O

State	Premium	Coverage limits[a]	Policy form[b]
VA[c]	$9,915	$1/$1	C
MN	9,866	1/3	C
VT	9,820	1/1	C
MA[d,e]	9,577	1/3	O
UT[d]	8,581	1/3	O
TX[c]	8,036	1/1	O
NM	7,932	0.5/[f]	O
NC	7,924	1/1	C
IN	7,760	0.5/[f]	O
MT	7,264	0.5/1.5	C
SC	5,809	[f]/[f]	O
AR	5,407	1/1	C

[a] Coverage limits are per occurrence/in aggregate. Figures are in millions.

[b] O = occurrence; C = claims-made.

[c] Leading insurer has multiple-rating territories. Premium shown is for territory with the largest number of physicians of this specialty.

[d] Leading insurer offers both occurrence and claims-made policy forms.

[e] Premium shown is conditional upon final approval of state insurance department.

[f] None.

Table II.4: Malpractice Insurance Premiums Paid by Physicians in Obstetrics/Gynecology by State as of July 1, 1985

State	Premium	Coverage limits[a]	Policy form[b]
FL[c]	$51,112	$1/$1	C
DC[d]	43,833	5/5	C
MD[c,d]	42,434	1/3	O
IL[c]	42,184	1/3	O
HI	37,652	1/3	C
CA[c]	34,816	0.5/1.5	C
CT[d]	32,901	1/3	O
MO	32,480	1/1	O
NY[c,d]	30,818	1/3	O
OR	27,495	1/3	O
AZ	26,767	1/1	C
ND	25,994	1/1	C
WV[d]	25,897	1/3	O
KS	25,761	3.2/6.6	C
AK	25,336	2/4	C
IA	24,901	1/1	C
WI	24,508	[f]/[f]	O
WA	24,464	1/3	O
ID[d]	24,043	1/3	O
GA	23,781	1/1	C
RI	23,521	1/3	O
NV	22,592	0.5/1.5	C
ME	22,530	1/3	C
SD	21,220	1/1	C
KY[d]	20,766	1.2/1.6	O
NH	20,755	1/3	O
NJ	20,304	1/3	O
PA[c]	20,196	1.2/3.6	O
MI[c]	19,931	0.2/0.6	O
WY	18,343	1/1	O
VT	18,250	1/1	C
CO	18,136	1/1	O
AL[d]	17,652	1/1	C
NC	16,904	1/1	C
TN	16,614	1/3	C
VA[c]	16,270	1/1	C
DE[d]	16,117	1/3	C
OH	14,775	2.2/2.6	O
MS[d]	14,014	1/1	C

State	Premium	Coverage limits[a]	Policy form[b]
UT[d]	$13,376	$1/$3	O
MA[d,e]	12,928	1/3	O
MN	11,808	1/3	C
TX[c]	11,609	1/1	O
MT	11,540	0.5/1.5	C
IN	11,380	0.5/[f]	O
LA	11,310	1/2	O
NE	11,289	1/[f]	C
OK	10,953	5/5	O
NM	10,627	0.5/[f]	O
AR	9,992	1/1	C
SC	6,922	[f]/[f]	O

[a] Coverage limits are per occurrence/in aggregate. Figures are in millions.

[b] O = occurrence; C = claims-made.

[c] Leading insurer has multiple-rating territories. Premium shown is for territory with the largest number of physicians of this specialty.

[d] Leading insurer offers both occurrence and claims-made policy forms.

[e] Premium shown is conditional upon final approval of state insurance department.

[f] None.

Table II.5: Malpractice Insurance Premiums Paid by Physicians in Orthopedic Surgery by State as of July 1, 1985

State	Premium	Coverage limits[a]	Policy form[b]
IL[c]	$56,088	$1/$3	O
DC[d]	43,833	5/5	C
AZ	41,919	3/3	C
FL[c]	40,925	1/1	C
HI	37,652	1/3	C
AK	35,431	2/4	C
MI[c]	34,410	1/1	O
CT[d]	32,901	1/3	O
NY[c, d]	31,983	1/3	O
NH	27,676	1/3	O
MO	27,608	1/1	O
WV[d]	25,897	1/3	O
WA	25,690	1/3	O
KY[d]	25,217	1.2/1.6	O
NJ	25,172	1/3	O
MD[c, d]	24,959	1/3	O
KS	24,331	3.2/6.6	C
ID[d]	24,043	1/3	O
RI	23,521	1/3	O
NV	22,592	0.5/1.5	C
ME	22,530	1/3	C
ND	22,302	1/1	C
OR	21,995	1/3	O
IA	21,667	1/1	C
CA[c]	21,456	0.5/1.5	C
WI	20,845	[f]	O
GA	20,407	1/1	C
PA[c]	19,074	1.2/3.6	O
DE[d]	18,803	1/3	C
WY	18,343	1/1	O
SD	18,206	1/1	C
CO	18,136	1/1	O
TN	17,823	1/3	C
AL[d]	17,652	1/1	C
OH	16,716	2.2/2.6	O
LA	15,697	1/2	O
MA[d, e]	15,322	1/3	O
VT	14,637	1/1	C
MN	14,435	1/3	C

State	Premium	Coverage limits[a]	Policy form[b]
MS[d]	$14,014	$1/$1	C
VA[c]	13,967	1/1	C
NE	13,441	1/1	C
UT[d]	13,376	1/3	O
NC	11,812	1/1	C
MT	11,540	0.5/1.5	C
OK	10,953	5/5	O
IN	10,605	0.5/[f]	O
TX[c]	10,121	1/1	O
SC	9,150	[f]/[f]	O
AR	8,028	1/1	C
NM	7,932	0.5/[f]	O

[a] Coverage limits are per occurrence/in aggregate. Figures are in millions.

[b] O = occurrence; C = claims-made.

[c] Leading insurer has multiple-rating territories. Premium shown is for territory with the largest number of physicians of this specialty.

[d] Leading insurer offers both occurrence and claims-made policy forms.

[e] Premium shown is conditional upon final approval of state insurance department.

[f] None.

States With Multiple-Rating Territories

California
1. Northern California
2. San Diego
3. Southern California

Florida
1. Dade and Broward Counties
2. Rest of the state

Michigan
1. Macomb, Oakland, and Wayne Counties
2. Rest of the state

Maryland
1. Rest of the state
2. Montgomery, Prince Georges, Howard, and Anne Arundel Counties
3. Baltimore City and County

Illinois
1. Cook, Dupage, Kane, Lake Madison, McHenry, St. Clair, and Vermilion Counties
2. Champaign, Jackson, Kankakee, Lasalle, Sangamon, and Will Counties
3. Rest of the state

New York
1. Long Island
2. Bronx, Kings, Queens, Richmond, Rockland, and Sullivan Counties
3. Manhattan, Orange, Ulster, and Westchester Counties
4. Rest of the state

Pennsylvania
1. Delaware, Montgomery, and Philadelphia Counties
2. Rest of the state
3. Allegheny County
4. Bucks and Chester Counties

Texas
1. Rest of the state, Counties of Brazoria, Galveston
2. Harris, Jefferson, and Montgomery Counties

Virginia
1. Arlington, Fairfax, Fauquier, Loudoun, and Prince William Counties
2. Gloucester, Isle of Wight, James City, Surry, and York Counties
3. Rest of the state
4. Charles City, Chesterfield, Dinwiddie, Goochland, Henrico, Hanover, New Kent, Powhatan, and Prince George Counties

Claims-Made Policy Premiums by Coverage Limits for States With Multiple-Rating Territories[a] as of July 1, 1985

	$0.5M/$1.5M	$1M/$1M	$1M/$3M
Internal medicine (no surgery)			
California:			
1	$3,772		
2	4,416		
3	4,800		
Florida:			
1		$9,228	
2		6,154	
Maryland:			
1			$3,694
2			4,412
3			4,800
New York:			
1			11,670
2			10,201
3			9,030
4			5,280
Virginia:			
1		2,940	
2		2,723	
3		2,179	
4		1,851	
General/family practice (minor surgery)			
California:			
1	6,392		
2	7,476		
3	8,124		
Florida:			
1		18,229	
2		12,156	
Maryland:			
1			6,055
2			7,314
3			7,991
New York:			
1			15,553
2			13,596
3			12,034
4			7,037

	$0.5M/$1.5M	$1M/$1M	$1M/$3M
General/family practice (minor surgery)			
Virginia:			
1		$5,687	
2		5,270	
3		4,214	
4		3,581	
General surgery			
California:			
1	$18,240		
2	21,336		
3	23,172		
Florida:			
1		46,087	
2		30,736	
Maryland:			
1			$15,481
2			18,892
3			20,729
New York:			
1			34,819
2			30,437
3			26,942
4			15,754
Virginia:			
1		15,750	
2		14,589	
3		11,667	
4		9,915	
Anesthesiology			
California:			
1	11,722		
2	15,304		
3	16,620		
Florida:			
1		40,996	
2		27,339	
Maryland:			
1			15,481
2			18,892
3			20,729

	$0.5M/$1.5M	$1M/$1M	$1M/$3M
Anesthesiology			
New York:			
1			$22,937
2			20,050
3			17,748
4			10,378
Virginia:			
1		$15,750	
2		14,589	
3		11,667	
4		9,915	
Obstetrics/gynecology			
California:			
1	$27,400		
2	32,048		
3	34,816		
Florida:			
1		76,641	
2		51,112	
Maryland:			
1			36,393
2			44,580
3			48,988
New York:			
1			59,262
2			51,805
3			45,855
4			26,813
Virginia:			
1		21,963	
2		20,347	
3		16,270	
4		13,828	
Orthopedic surgery			
California:			
1	21,456		
2	25,100		
3	27,272		
Florida:			
1		61,363	
2		40,925	

	$0.5M/$1.5M	$1M/$1M	$1M/$3M
Orthopedic surgery			
Maryland:			
1			$21,457
2			26,232
3			28,803
New York:			
1			61,522
2			53,780
3			47,604
4			27,835
Virginia:			
1		$18,855	
2		17,468	
3		13,967	
4		11,871	
Neurosurgery			
California:			
1	$24,248		
2	28,356		
3	30,804		
Florida:			
1		97,010	
2		64,696	
Maryland:			
1			21,457
2			26,232
3			28,803
New York:			
1			72,566
2			63,434
3			56,150
4			32,832
Virginia:			
1		32,835	
2		30,418	
3		24,324	
4		20,673	

[a] See appendix III for a list of territories.

Note: Coverage limits are in millions of dollars.

Occurrence Policy Premiums by Coverage Limits for States With Multiple-Rating Territories[a] as of July 1, 1985

	$0.2M/$0.6M	$1M/$1M	$1M/$3M	$1.2M/$3.6M
Internal medicine (no surgery)				
Illinois:				
1			$7,420	
2			6,032	
3			4,640	
Maryland:				
1			3,494	
2			4,179	
3			4,547	
Michigan:				
1		$8,445		
2		5,574		
New York:				
1			13,413	
2			11,726	
3			10,380	
4			6,069	
Pennsylvania:				
1				$4,619
2				2,244
3				2,479
4				3,657
Texas:				
1		1,437		
2		2,352		
General/family practice (minor surgery)				
Illinois:				
1			11,592	
2			9,368	
3			7,144	
Maryland:				
1			5,743	
2			6,942	
3			7,587	
Michigan:				
1	$7,224			
2	4,779			

	$0.2M/$0.6M	$1M/$1M	$1M/$3M	$1.2M/$3.6M
General/family practice (minor surgery)				
New York:				
1			$17,876	
2			15,628	
3			13,833	
4			8,088	
Pennsylvania:				
1				$8,775
2				4,264
3				4,709
4				6,948
Texas:				
1		$2,156		
2		3,528		
General surgery				
Illinois:				
1			28,280	
2			22,716	
3			17,156	
Maryland:				
1			14,720	
2			17,970	
3			19,719	
Michigan:				
1	$19,704			
2	13,003			
New York:				
1			40,021	
2			34,986	
3			30,969	
4			18,107	
Pennsylvania:				
1				30,024
2				14,586
3				16,111
4				23,770
Texas:				
1		8,036		
2		13,151		

	$0.2M/$0.6M	$1M/$1M	$1M/$3M	$1.2M/$3.6M
Anesthesiology				
Illinois:				
1			$22,280	
2			22,716	
3			17,156	
Maryland:				
1			14,720	
2			17,970	
3			19,719	
Michigan:				
1		$24,994		
2		16,496		
New York:				
1			26,363	
2			23,047	
3			20,401	
4			11,928	
Pennsylvania:				
1				$30,024
2				14,586
3				16,111
4				23,770
Texas:				
1		8,036		
2		13,151		
Obstetrics/gynecology				
Illinois:				
1			42,184	
2			33,840	
3			25,496	
Maryland:				
1			34,637	
2			42,434	
3			46,632	
Michigan:				
1	$30,198			
2	19,931			
New York:				
1			68,116	
2			59,547	
3			52,709	
4			30,818	

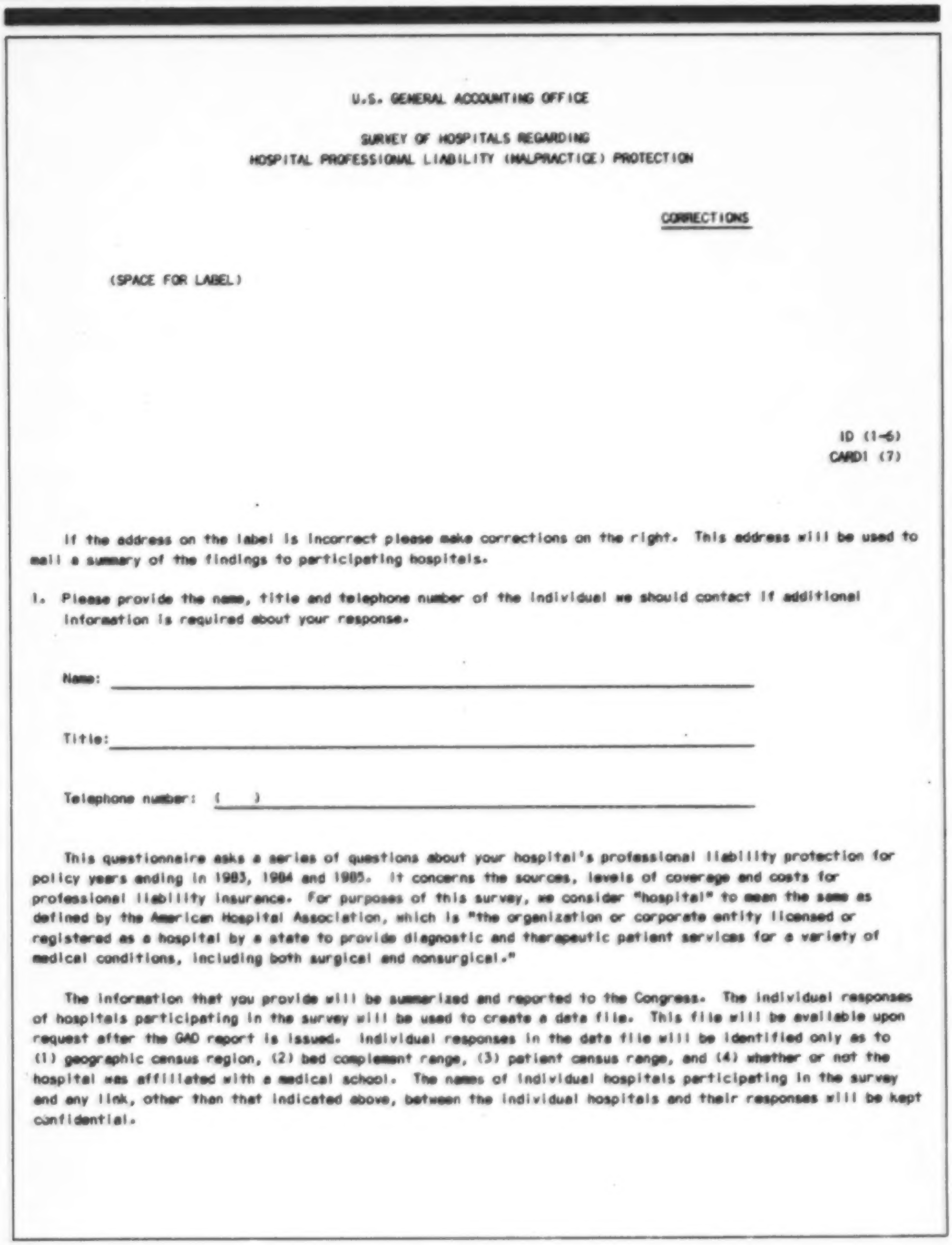
	$0.2M/$0.6M	$1M/$1M	$1M/$3M	$1.2M/$3.6M
Obstetrics/gynecology				
Pennsylvania:				
1				$41,570
2				20,196
3				21,068
4				13,551
Texas:				
1		$11,609		
2		18,995		
Orthopedic surgery				
Illinois:				
1			$56,088	
2			44,964	
3			33,840	
Maryland:				
1			20,410	
2			24,959	
3			27,409	
Michigan:				
1		52,305		
2		34,410		
New York:				
1			70,713	
2			61,817	
3			54,719	
4			31,993	
Pennsylvania:				
1				32,261
2				19,074
3				18,589
4				31,083
Texas:				
1		10,121		
2		16,560		
Neurosurgery				
Illinois:				
1			56,088	
2			44,964	
3			33,840	

	$0.2M/$0.6M	$1M/$1M	$1M/$3M	$1.2M/$3.6M
Neurosurgery				
Maryland:				
1			$20,410	
2			24,959	
3			27,409	
Michigan:				
1		$52,305		
2		34,410		
New York:				
1			83,407	
2			72,914	
3			64,542	
4			37,736	
Pennsylvania:				
1				$41,570
2				20,196
3				21,068
4				13,551
Texas:				
1		11,609		
2		18,995		

[a] See appendix III for a list of territories.

Note: Coverage limits are in millions of dollars.

Survey of Hospitals Regarding Hospital Professional Liability (Malpractice) Protection



U.S. GENERAL ACCOUNTING OFFICE

SURVEY OF HOSPITALS REGARDING
HOSPITAL PROFESSIONAL LIABILITY (MALPRACTICE) PROTECTION

CORRECTIONS

(SPACE FOR LABEL)

ID (1-6)
CARD1 (7)

If the address on the label is incorrect please make corrections on the right. This address will be used to mail a summary of the findings to participating hospitals.

1. Please provide the name, title and telephone number of the individual we should contact if additional information is required about your response.

Name: ____________________________________

Title: ____________________________________

Telephone number: (___) ____________________________

This questionnaire asks a series of questions about your hospital's professional liability protection for policy years ending in 1983, 1984 and 1985. It concerns the sources, levels of coverage and costs for professional liability insurance. For purposes of this survey, we consider "hospital" to mean the same as defined by the American Hospital Association, which is "the organization or corporate entity licensed or registered as a hospital by a state to provide diagnostic and therapeutic patient services for a variety of medical conditions, including both surgical and nonsurgical."

The information that you provide will be summarized and reported to the Congress. The individual responses of hospitals participating in the survey will be used to create a data file. This file will be available upon request after the GAO report is issued. Individual responses in the data file will be identified only as to (1) geographic census region, (2) bed complement range, (3) patient census range, and (4) whether or not the hospital was affiliated with a medical school. The names of individual hospitals participating in the survey and any link, other than that indicated above, between the individual hospitals and their responses will be kept confidential.

HOSPITAL BACKGROUND

Policy Year

1983	1984	1985

2. Indicate the beginning and ending dates for the hospital's policy years which end in 1983, 1984 and 1985. A policy year is the 365 or 366 days between the annual premium or payment dates. If your hospital's policy year is less than or greater than this please explain.

	Mo./Day/Yr.	Mo./Day/Yr.	Mo./Day/Yr.
BEGINNING DATE - - - -	/ /	/ /	/ /
ENDING DATE - - - - -	/ / 83	/ / 84	/ / 85

(8-43)

3. What was the bed complement of the hospital (excluding bassinets and incubators) on the first day of each policy year?

(44-55)

4. How many inpatient days (excluding newborn and bassinet days) did the hospital have for each policy year? If your 1985 policy year has not concluded, please estimate inpatient days for that year.

(56-73)

5. How many outpatient visits (excluding emergency room visits) did the hospital have for each policy year? If your 1985 policy year has not concluded, please estimate outpatient visits for that year.

*2 (8-25)

6. How many emergency room visits did the hospital have for each policy year? If your 1985 policy year has not concluded, please estimate emergency room visits for that year.

(26-43)

7. Was the hospital affiliated with a medical school on the first day of each policy year? (CHECK ALL THAT APPLY.)

(1) Yes, through an intern and/or residency program - -	[ ]	[ ]	[ ]
(2) Yes, through another program (EXPLAIN) ____________ ____________________________	[ ]	[ ]	[ ]
(3) No - - - - - - - - - - - - - - - - - -	[ ]	[ ]	[ ]

(44-52)

2

BEST COPY AVAILABLE

PRIMARY PROTECTION

THE FOLLOWING QUESTIONS RELATE TO THE SOURCES, LEVELS, AND COSTS OF PRIMARY (FIRST LEVEL) PROFESSIONAL LIABILITY (MALPRACTICE) PROTECTION WHICH WAS IN FORCE ON THE FIRST DAY OF EACH POLICY YEAR. IF ANY QUESTIONS ARE NOT APPLICABLE, INSERT "N/A" IN THE APPROPRIATE BOX(ES).

8. On the first day of each of the hospital's policy years, through what source(s) was primary (first level) professional liability (malpractice) protection provided? (CHECK ALL THAT APPLY.)

	Policy Year 1983	Policy Year 1984	Policy Year 1985
(1) Self-insurance trust fund (single hospital) - - - -	☐	☐	☐
(2) Self-insurance trust fund (group of hospitals) - -	☐	☐	☐
(3) Commercial insurance - - - - - - - - - - - -	☐	☐	☐
(4) Hospital-formed insuring company or trust (captive insurer) - - - -	☐	☐	☐
(5) State fund (such as catastrophic loss fund, patient compensation fund, etc.) - - - - - - - -	☐	☐	☐
(6) Did not insure (went bare) - - - - - - - - - -	☐	☐	☐

(53-70)

Policy Year

9. If the hospital provided its primary professional liability protection through a self-insurance trust fund, show the amount of the self-insured retention in force on the first day of each policy year.

	1983	1984	1985
(1) Per occurrence limits - - - - - - - - - - - - and	$	$	$
(2) Aggregate limits - - - - - - - - - - - - - - -	$	$	$

*3 (8-37)

10. If the hospital provided its primary professional liability protection through a self-insurance trust fund, show the hospital's contribution to its self-insurance trust fund for each policy year.

--Separate professional from general liability, if possible.

	1983	1984	1985
	$	$	$

(38-58)

11. Did this contribution include coverage of comprehensive general liability? (CHECK ONE FOR EACH YEAR.)

	1983	1984	1985
(1) Yes - - - - - - - - - - - - - - - - - - -	( )	( )	( )
(2) No -	( )	( )	( )

(59-61)

4

	Policy Year		
	1983	1984	1985

12. If the hospital purchased primary professional liability protection what maximum dollar limits did the hospital have on the first day of each policy year.

	1983	1984	1985
(1) Per occurrence limits - - - - - - - - - - - - and	$	$	$
(2) Aggregate limits - - - - - - - - - - - - - -	$	$	$

*4(8-37)

13. If the hospital purchased primary professional liability protection, was there a deductible or quota share applicable for first dollar losses for the coverage in force on the first day of each policy year? (CHECK ONE FOR EACH YEAR.)

	1983	1984	1985
(1) Yes - - - - - - - - - - - - - - - - - -	☐	☐	☐
(2) No - - - - - - - - - - - - - - - - - -	☐	☐	☐

(38-40)

14. If yes, show amount of deductible or quota share for the coverage in force on the first day of each policy year, as applicable.

	1983	1984	1985
(1) Per occurrence - - - - - - - - - - - - - - and	$	$	$
(2) Aggregate - - - - - - - - - - - - - - - -	$	$	$

(41-64)

Policy Year

15. If the hospital purchased primary professional liability protection, what was the hospital's total cost (premiums) for each policy year?

—Separate professional from general liability, if possible.

—Include any retrospective premium adjustments.

—If you had more than one policy during a policy year, be sure to prorate the premium on the basis of one policy year.

	1983	1984	1985
15.	$	$	$

*5 (8-28)

16. Did this cost (premiums) for primary protection include coverage for comprehensive general liability? (CHECK ONE FOR EACH YEAR.)

	1983	1984	1985
(1) Yes	☐	☐	☐
(2) No	☐	☐	☐

(29-31)

17. Has a retrospective premium adjustment been included in this cost for primary protection? (CHECK ONE FOR EACH YEAR.)

	1983	1984	1985
(1) Yes, adjustment included	☐	☐	☐
(2) Adjustments possible, but not included	☐	☐	☐
(3) Adjustments not possible with our coverage	☐	☐	☐

(32-34)

ABOVE PRIMARY PROTECTION

THE FOLLOWING QUESTIONS RELATE TO THE SOURCES, LEVELS, AND COSTS OF PROFESSIONAL LIABILITY (MALPRACTICE) PROTECTION ABOVE PRIMARY (SUCH AS EXCESS AND/OR UMBRELLA COVERAGE) WHICH WAS IN FORCE ON THE FIRST DAY OF EACH POLICY YEAR. IF ANY QUESTIONS ARE NOT APPLICABLE, INSERT "N/A" IN THE APPROPRIATE BOX(ES).

18. On the first day of each of the hospital's policy years, through what source(s) was professional liability (malpractice) protection above primary (such as excess and/or umbrella coverage) obtained? (CHECK ALL THAT APPLY.)

	Policy Year		
	1983	1984	1985
(1) Commercial insurance	[ ]	[ ]	[ ]
(2) Hospital-formed insuring company or trust (captive insurer)	[ ]	[ ]	[ ]
(3) State fund (such as catastrophic loss fund, patient compensation fund, etc.)	[ ]	[ ]	[ ]
(4) Did not insure (went bare)	[ ]	[ ]	[ ]

(35-46)

19. What maximum dollar limits of professional liability protection above primary did the hospital have on the first day of each policy year?

	1983	1984	1985
(1) Per occurrence limits and	$	$	$
(2) Aggregate limits	$	$	$

(47-76)

	Policy Year		
	1983	1984	1985
20. What was the hospital's total cost (premiums) for professional liability protection above primary for each policy year? —Separate professional from general liability, if possible. —Include any retrospective premium adjustments. —If you had more than one policy during a policy year, be sure to prorate the premium on the basis of one policy year.	$	$	$
			*6 (8-28)
21. Did this cost (premiums) for above primary protection include coverage for comprehensive general liability? (CHECK ONE FOR EACH YEAR.)			
(1) Yes - - - - - - - - - - - - - - - - - -	☐	☐	☐
(2) No - - - - - - - - - - - - - - - - - -	☐	☐	☐
			(29-31)
22. Has a retrospective premium adjustment been included in this cost for above primary protection? (CHECK ONE FOR EACH YEAR.)			
(1) Yes, adjustment included - - - - - - - - - -	☐	☐	☐
(2) Adjustments possible, but not included - - - - -	☐	☐	☐
(3) Adjustments not possible with our coverage - - - -	☐	☐	☐
			(32-34)

Policy Year

	1983	1984	1985

23. What policy form of professional liability protection did the hospital have for each policy year? (This should be the same for both primary and above primary.) (CHECK ONE FOR EACH YEAR.)

	1983	1984	1985
(1) Occurrence - - - - - - - - - - - - - - - -	[ ]	[ ]	[ ]
(2) Claims made - - - - - - - - - - - - - - - -	[ ]	[ ]	[ ]

(35-37)

24. For each policy year, what was the total cost to the hospital for uninsured (paid out of operations) professional liability losses (such as amounts paid out (1) in relation to a deductible or quota share and/or (2) losses above the coverage limits of purchased insurance or actuarially-determined contributions to a self-insurance fund)?

	1983	1984	1985
	$	$	$

(38-61)

25. If you feel that questions 8 - 24 did not allow you to adequately state the type of professional liability protection your hospital has, please do your best to answer the questions you can and then use the space below to describe the type of protection you have. (62)

26. Listed below are a number of reasons insurance premiums and/or contributions to insurance funds may change from one year to the next. For each of the two time periods, policy year 1983 to policy year 1984 and policy year 1984 to policy year 1985 (on the next page), indicate the extent to which you feel each reason contributed to premium or fund contribution changes for your hospital for primary and above primary professional liability coverage combined.

Policy Year 1983 to Policy Year 1984	(CHECK ONE BOX FOR EACH REASON.)						
	Very great extent (1)	Great extent (2)	Moderate extent (3)	Some extent (4)	Little or no extent (5)	Does not apply (6)	
1. Change in annual limits for your hospital's coverage							(63)
2. Change in the amount of retention in the self-insurance trust fund							(64)
3. Change in the amount of deductible							(65)
4. A change in policy form of protection purchased by your hospital							(66)
5. Increased contributions required by a state fund (such as catastrophic loss fund, patient compensation fund, etc.)							(67)
6. Decreased contributions required by a state fund							(68)
7. Increase in the number of claims filed against your hospital							(69)
8. Decrease in the number of claims filed against your hospital							(70)
9. Increase in the amount paid for claims closed against your hospital							(71)
10. Decrease in the amount paid for claims closed against your hospital							(72)
11. Increase in the availability of the desired levels of coverage to buyers							(73)
12. Decrease in the availability of the desired levels of coverage to buyers							(74)
13. Change in brokers							(75)
14. Other (SPECIFY)							(76)

26. (Continued)

	(CHECK ONE BOX FOR EACH REASON.)						
Policy Year 1984 to Policy Year 1985	Very great extent (1)	Great extent (2)	Moderate extent (3)	Some extent (4)	Little or no extent (5)	Does not apply (6)	
1. Change in annual limits for your hospital's coverage							*7(8)
2. Change in the amount of retention in the self-insurance trust fund							(9)
3. Change in the amount of deductible							(10)
4. A change in policy form of protection purchased by your hospital							(11)
5. Increased contributions required by a state fund (such as catastrophic loss fund, patient compensation fund, etc.)							(12)
6. Decreased contributions required by a state fund							(13)
7. Increase in the number of claims filed against your hospital							(14)
8. Decrease in the number of claims filed against your hospital							(15)
9. Increase in the amount paid for claims closed against your hospital							(16)
10. Decrease in the amount paid for claims closed against your hospital							(17)
11. Increase in the availability of the desired levels of coverage to buyers							(18)
12. Decrease in the availability of the desired levels of coverage to buyers							(19)
13. Change in brokers							(20)
14. Other (SPECIFY)							(21)

27. Did (will) the availability of liability insurance pose a problem for your hospital in obtaining the desired coverage of professional liability for your hospital's policy year ending in 1986 (i.e., did (will) the capacity of the insurance market have any adverse impact upon your hospital's ability to obtain desired coverage)? (CHECK ONE.) (22)

(1) [ ] Yes (PLEASE EXPLAIN.) ____________________

(2) [ ] No

28. Did (will) the affordability of liability insurance pose a problem for your hospital in obtaining the desired coverage of professional liability for your hospital's policy year ending in 1986. (CHECK ONE.) (23)

(1) [ ] Yes (PLEASE EXPLAIN.) ____________________

(2) [ ] No

29. If you have any comments on any questions in the questionnaire or on professional liability insurance in general, please write them here. (24)

Number of Hospitals in the Universe, GAO Sample, and Survey Response

	Hospitals		
	Universe	**Sample**	**Responses**
Total	**5,783**	**1,782**	**1,248**
By hospital size (no. of beds):			
6 to 24	224	47	22
25 to 49	986	182	111
50 to 99	1,414	319	195
100 to 199	1,382	427	287
200 to 299	726	253	189
300 to 399	438	167	138
400 to 499	274	147	114
500 or more	339	240	192
By census region:			
1. New England	251	136	110
2. Middle Atlantic	608	264	197
3. South Atlantic	820	306	214
4. East North Central	900	292	211
5. East South Central	488	103	64
6. West North Central	796	177	126
7. West South Central	845	168	110
8. Mountain	371	153	109
9. Pacific	704	183	107

Estimated Hospital Data and Related Sampling Errors for Policy Years 1983, 1984, and 1985

Table VIII.1: Hospital Malpractice Insurance Costs and Related Sampling Errors by Type of Expenditure

Dollars in millions

	1983		1984		1985	
Expenditure	**Amount**	**Sampling error**[a]	**Amount**	**Sampling error**[a]	**Amount**	**Sampling error**[a]
Total costs	**$849.4**	**$47.7**	**$959.8**	**$54.3**	**$1,336.0**	**$137.3**
Contributions to self-insurance trust funds	255.8	32.1	289.3	37.0	350.6	39.0
Premiums for purchased insurance	562.4	30.5	628.2	34.5	866.8	47.0
Uninsured losses	31.1	11.5	42.2	12.8	118.6[b]	122.6

[a] Sampling errors are stated at the 95-percent confidence level.

[b] Estimate subject to a large sampling error and should be used with caution.

Note: Detail may not add to total due to independent estimation.

Table VIII.2: Distribution of Annual Malpractice Insurance Costs and Related Sampling Errors for Hospitals

Figures in percents

	1983		1985	
Annual cost	**Hospitals**	**Sampling error**[a]	**Hospitals**	**Sampling error**[a]
Less than $10,000	14.2	2.4	9.2	2.2
$10,000 to $24,999	19.3	2.6	16.4	2.7
$25,000 to $49,999	16.9	2.3	16.9	2.5
$50,000 to $99,999	15.3	2.0	13.8	1.9
$100,000 to $249,999	19.0	1.7	21.2	2.0
$250,000 to $499,999	8.4	1.1	11.1	1.4
$500,000 to $999,999	4.7	.7	6.7	.9
$1 million or more	2.1	.4	4.6	.6

[a] Sampling errors are stated at the 95-percent confidence level.

Note: The universe of hospitals was 5,513 in 1983 and 5,656 in 1985.

Table VIII.3: Distribution of Malpractice Insurance Costs Per Inpatient Day and Related Sampling Errors

Figures in percents

	1983		1984		1985	
Insurance costs per day	**Hospitals**	**Sampling error[a]**	**Hospitals**	**Sampling error[a]**	**Hospitals**	**Sampling error[a]**
$1	34.4	3.0	25.8	2.9	13.8	2.5
2	25.9	2.9	25.5	2.8	19.3	2.6
3	14.6	2.2	14.7	2.4	15.5	2.5
4	7.6	1.3	9.9	1.5	11.9	2.2
5	5.4	1.2	6.1	1.4	8.8	1.8
6	2.9	.9	4.8	1.1	5.5	1.3
7	2.6	1.2	3.2	1.3	4.5	1.3
8	1.1	.6	2.2	.8	3.9	1.1
9 to 10	2.2	.8	2.9	1.0	4.8	1.1
11 to 20	2.3	.8	3.4	1.0	9.3	1.5
Over 20	1.0	.6	1.5	.6	2.7	.8

[a] Sampling errors are stated at the 95-percent confidence level.

Note: The universe of hospitals was 5,274 in 1983, 5,434 in 1984, and 5,559 in 1985.

Table VIII.4: Average Malpractice Insurance Costs Per Inpatient Day and Related Sampling Errors by Size of Hospital and Region

	1983		1984		1985	
Group	**Cost per day**	**Sampling error[a]**	**Cost per day**	**Sampling error[a]**	**Cost per day**	**Sampling error[a]**
All hospitals	**$3.02**	**$0.20**	**$3.81**	**$0.27**	**$5.60**	**$0.41**
By hospital size (no. of beds):						
Fewer than 50	2.72	.60	3.29	.68	4.60	.72
50 to 99	2.72	.50	3.47	.52	5.10	.62
100 to 199	2.86	.32	3.88	.62	5.74	.78
200 to 299	3.16	.39	3.56	.42	5.15	.56
300 to 399	3.65	.46	4.78	1.17	8.27	3.56
400 to 499	3.79	.70	5.03	1.32	7.37	1.76
500 or more	4.30	.42	5.17	.55	6.94	.68
By region:						
1. New England	2.48	.33	2.79	.33	4.31	.55
2. Middle Atlantic	3.18	.26	3.69	.54	5.10	.74
3. South Atlantic	2.75	.35	3.78	.79	5.16	.63
4. East North Central	3.30	.47	4.30	.65	7.38	1.96
5. East South Central	2.15	.67	2.49	.63	3.86	.87
6. West North Central	1.61	.15	2.19	.27	3.60	.51
7. West South Central	1.53	.21	2.27	.55	3.30	.61
8. Mountain	3.25	.47	4.29	.72	6.78	1.40
9. Pacific	6.71	1.34	7.86	1.49	10.16	1.37

[a] Sampling errors are stated at the 95-percent confidence level.

Note: The universe of hospitals was 5,487 in 1983; 5,556 in 1984; and 5,626 in 1985.

Table VIII.5: Distribution of Changes in Malpractice Insurance Costs Per Inpatient Day From 1983 to 1985 and Related Sampling Errors

Figures in percents

Changes	Hospitals	Sampling error[a]
Increases of less than 10% or decreases	15.1	2.4
Increases of 10% to 49%	24.7	2.7
Increases of 50% to 99%	21.1	2.6
Increases of 100% to 199%	24.1	2.7
Increases of 200% to 299%	8.0	2.0
Increases of 300% or more	6.7	1.7

[a] Sampling errors are stated at the 95-percent confidence level.

Note: The universe of hospitals was 5,472.

Table VIII.6: Distribution of Changes in Malpractice Insurance Costs Per Inpatient Day From 1983 to 1985 and Related Sampling Errors by Region

Changes in percents

		Changes							
		Increases of less than 10% or decreases		Increases					
				10 to 49 percent		50 to 99 percent		100 percent or more	
Group	**No. of hospitals**	**Hospitals**	**Sampling error**[a]	**Hospitals**	**Sampling error**[a]	**Hospitals**	**Sampling error**[a]	**Hospitals**	**Sampling error**[a]
All hospitals	**5,472**	**15.1**	**2.4**	**24.7**	**2.7**	**21.1**	**2.6**	**38.8**	**3.2**
By region:									
1. New England	243	19.3	6.0	27.7	6.4	21.0	6.2	32.1	6.3
2. Middle Atlantic	566	25.0	5.6	36.9	6.0	17.1	4.4	21.0	5.0
3. South Atlantic	780	19.4	5.4	21.9	5.7	21.2	5.2	37.4	6.6
4. East North Central	861	11.3	3.6	25.2	6.0	24.4	6.0	38.3	6.8
5. East South Central	441	21.2	13.3	14.5	9.6	6.6	4.3	57.7	13.8
6. West North Central	792	7.8	4.7	18.3	6.8	26.2	8.6	47.7	9.4
7. West South Central	750	16.8	10.3	22.4	11.0	22.2	10.8	38.5	12.6
8. Mountain	354	8.7	4.7	28.7	7.5	21.2	6.7	41.4	8.0
9. Pacific	685	11.2	6.1	30.9	8.7	22.6	8.0	34.7	9.1

[a] Sampling errors are stated at the 95-percent confidence level.

Note: Detail may not add to total due to independent estimation.

Table VIII.7: Distribution of Changes in Malpractice Insurance Costs Per Inpatient Day From 1983 to 1985 and Related Sampling Errors by Size of Hospital

Changes in percents

		Changes									
		Increases of less than 50% or decreases		Increases							
				50 to 99 percent		100 to 199 percent		200 to 299 percent		300 percent or more	
Group	No. of hospitals	Hospitals	Sampling error[a]	Hospitals	Sampling error[a]	Hospitals	Sampling error[a]	Hospitals	Sampling error[a]	Hospitals	Sampling error[a]
All hospitals	**5,472**	**40.0**	**3.1**	**21.1**	**2.6**	**24.1**	**2.7**	**8.0**	**2.0**	**6.7**	**1.7**
By hospital size (no. of beds):											
Fewer than 50	1,127	36.5	9.7	22.1	8.5	20.5	7.7	15.2	7.8	5.7	3.9
50 to 99	1,368	33.0	6.8	21.4	5.4	30.8	6.7	5.4	3.0	9.4	4.8
100 to 199	1,304	40.9	5.4	19.3	4.4	25.2	4.9	8.7	3.3	5.9	2.7
200 to 299	707	54.7	6.6	15.2	5.0	20.4	5.2	5.3	2.9	4.4	2.6
300 to 399	412	46.8	7.1	24.6	6.4	17.7	5.1	4.1	2.6	6.8	3.5
400 to 499	255	37.7	7.3	30.0	7.0	20.9	6.4	4.5	2.8	6.9	3.6
500 or more	299	39.8	4.8	25.7	4.4	23.1	4.2	4.8	2.2	6.5	2.2

[a] Sampling errors are stated at the 95-percent confidence level.

Note: Detail may not add to total due to independent estimation.

Table VIII.8: Average Annual Malpractice Insurance Cost Per Bed and Related Sampling Errors

		Average annual cost per bed	
Year	No. of hospitals	Amount	Sampling error[a]
1983	4,966	$999.66	$62.23
1984	5,138	1,231.44	83.40
1985	5,221	1,783.91	127.40

[a] Sampling errors are stated at the 95-percent confidence level.

Table VIII.9: Distribution of Decreases in Inpatient Days From 1983 to 1985 and Related Sampling Errors

Figures in percents

Decreases	Hospitals	Sampling error[a]
1 to 19%	41.0	2.6
20 to 39%	33.9	3.1
40% or more	9.2	2.1

[a] Sampling errors are stated at the 95-percent confidence level.

Note: 1. The universe of hospitals was 5,695.

Note: 2. The balance of about 16 percent of the hospitals had either no change or an increase in inpatient days.

Table VIII.10: Inpatient Days and Related Sampling Errors by Size of Hospital and Region

Figures in millions

	1983		1984		1985	
Group	**No. of days**	**Sampling error[a]**	**No. of days**	**Sampling error[a]**	**No. of days**	**Sampling error[a]**
All hospitals	**267.1**	**4.1**	**251.1**	**4.0**	**232.1**	**4.0**
By hospital size (no. of beds):						
Fewer than 50	7.5	.9	7.0	.9	5.9	.8
50 to 99	22.3	1.2	20.4	1.2	18.4	1.2
100 to 199	48.1	1.8	43.9	1.7	40.3	1.8
200 to 299	47.7	1.4	44.6	1.4	40.7	1.4
300 to 399	40.9	1.3	38.8	1.4	36.1	1.4
400 to 499	32.7	1.0	30.9	1.0	28.8	1.1
500 or more	67.8	2.5	65.5	2.4	61.9	2.4
By region:						
1. New England	14.1	.5	13.4	.5	12.7	.4
2. Middle Atlantic	50.7	1.6	49.6	1.7	47.0	1.8
3. South Atlantic	43.6	1.4	40.7	1.3	37.9	1.3
4. East North Central	51.0	1.6	47.2	1.5	42.4	1.5
5. East South Central	19.7	1.9	18.6	1.8	16.8	1.8
6. West North Central	23.4	1.2	20.9	1.1	18.8	1.0
7. West South Central	27.6	1.2	26.1	1.3	23.5	1.3
8. Mountain	10.1	.6	9.4	.6	8.6	.6
9. Pacific	26.9	1.5	25.2	1.5	24.3	1.5

[a] Sampling errors are stated at the 95-percent confidence level.

Note: 1. Detail may not add to total due to independent estimation.

Note: 2. The universe of hospitals was 5,696 in 1983; 5,747 in 1984; and 5,753 in 1985.

Table VIII.11: Distribution of Changes in Combined Per-Occurrence Limits From 1983 to 1985 and Related Sampling Errors

Figures in percents

Change	Hospitals	Sampling error[a]
Increased limits	34.3	2.8
Decreased limits	8.2	1.8
No change	57.4	3.1

[a]Sampling errors are stated at the 95-percent confidence level.

Note: The universe of hospitals was 5,597.

Table VIII.12: Distribution of Self-Insurance Trust Fund Only Source and Related Sampling Errors by Size of Hospital and Region

Self-insured and sampling error in percents

	1983			1985		
	Hospitals			Hospitals		
Group	Total	Self-insured	Sampling error[a]	Total	Self-insured	Sampling error[a]
All hospitals	5,697	5.6	1.4	5,732	5.7	1.5
By hospital size (no. of beds):						
Fewer than 50	1,169	3.6	2.8	1,197	7.3	4.5
50 to 99	1,405	6.7	3.9	1,405	6.7	3.9
100 to 199	1,361	6.5	2.5	1,372	5.0	2.3
200 to 299	716	3.8	2.7	716	3.2	2.5
300 to 399	438	4.8	3.3	438	4.1	3.1
400 to 499	269	7.8	4.0	265	4.8	3.0
500 or more	337	8.0	2.7	337	6.4	2.4
By region:						
1. New England	251	0.0	0.0	251	0.0	0.0
2. Middle Atlantic	600	1.6	1.3	600	.9	1.1
3. South Atlantic	814	8.9	4.2	814	8.9	4.2
4. East North Central	895	9.3	3.4	898	4.0	2.4
5. East South Central	482	12.7	9.3	480	23.4	13.2
6. West North Central	783	3.6	3.6	783	3.6	3.6
7. West South Central	806	3.2	2.4	845	3.1	2.3
8. Mountain	361	5.5	4.0	361	5.5	4.0
9. Pacific	704	3.0	2.9	700	3.6	3.1

[a]Sampling errors are stated at the 95-percent confidence level.

Note: Detail may not add to total due to independent estimation.

Table VIII.13: Distribution of Purchased Insurance Only Source and Related Sampling Errors by Size of Hospital and Region

Purchased and sampling error in percents

	1983			1985		
	Hospitals			Hospitals		
Group	Total	Purchased	Sampling error[a]	Total	Purchased	Sampling error[a]
All hospitals	**5,697**	**75.9**	**2.4**	**5,732**	**73.6**	**2.7**
By hospital size (no. of beds):						
Fewer than 50	1,169	85.2	6.4	1,197	79.1	8.2
50 to 99	1,405	85.6	5.2	1,405	82.3	5.6
100 to 199	1,361	73.8	4.9	1,372	72.1	4.9
200 to 299	716	76.2	5.2	716	77.0	5.2
300 to 399	438	60.2	6.6	438	59.3	6.7
400 to 499	269	55.3	7.6	265	58.0	7.5
500 or more	337	48.5	4.6	337	47.8	4.6
By region:						
1. New England	251	91.3	3.4	251	89.4	4.0
2. Middle Atlantic	600	80.0	3.9	600	81.4	3.8
3. South Atlantic	814	63.0	6.4	814	59.6	6.5
4. East North Central	895	70.6	4.6	898	72.3	4.6
5. East South Central	482	78.5	10.0	480	67.2	13.6
6. West North Central	783	87.5	6.0	783	87.5	6.0
7. West South Central	806	79.0	8.8	845	74.0	10.2
8. Mountain	361	65.8	7.8	361	64.3	7.9
9. Pacific	704	75.6	7.7	700	72.4	8.2

[a] Sampling errors are stated at the 95-percent confidence level.

Note: Detail may not add to total due to independent estimation.

Table VIII.14: Distribution of Self-Insurance and Purchased Insurance Combination Source and Related Sampling Errors by Size of Hospital and Region

Combination and sampling error in percents

	1983			1985		
	Hospitals		Sampling error[a]	Hospitals		Sampling error[a]
Group	Total	Combination		Total	Combination	
All hospitals	**5,697**	**16.3**	**2.0**	**5,732**	**18.9**	**2.2**
By hospital size (no. of beds):						
Fewer than 50	1,169	9.4	5.5	1,197	11.9	6.6
50 to 99	1,405	6.9	3.6	1,405	10.1	4.2
100 to 199	1,361	17.4	4.2	1,372	21.3	4.5
200 to 299	716	19.5	4.7	716	19.3	4.6
300 to 399	438	31.1	6.2	438	32.7	6.3
400 to 499	269	33.3	7.2	265	34.4	7.2
500 or more	337	35.7	4.3	337	39.0	4.4
By region:						
1. New England	251	8.1	3.4	251	10.0	4.0
2. Middle Atlantic	600	12.8	3.3	600	12.5	3.3
3. South Atlantic	814	26.3	5.3	814	30.1	5.8
4. East North Central	895	20.1	3.8	898	23.7	4.2
5. East South Central	482	6.0	3.9	480	7.7	4.3
6. West North Central	783	7.0	4.2	783	7.0	4.2
7. West South Central	806	12.7	8.0	845	18.7	9.8
8. Mountain	361	27.8	7.3	361	29.3	7.4
9. Pacific	704	21.4	7.4	700	24.0	7.8

[a] Sampling errors are stated at the 95-percent confidence level.

Note: Detail may not add to total due to independent estimation.

Table VIII.15: Distribution of No Coverage Source and Related Sampling Errors by Size of Hospital and Region

No coverage and sampling error in percents

	1983			1985		
	Hospitals			Hospitals		
Group	Total	No coverage	Sampling error[a]	Total	No coverage	Sampling error[a]
All hospitals	**5,697**	**2.1**	**0.8**	**5,732**	**1.8**	**0.7**
By hospital size (no. of beds):						
Fewer than 50	1,169	1.8	2.3	1,197	1.7	2.3
50 to 99	1,405	.9	1.6	1,405	.9	1.6
100 to 199	1,361	2.3	1.5	1,372	1.5	1.2
200 to 299	716	.5	.8	716	.5	.8
300 to 399	438	4.0	2.8	438	4.0	2.8
400 to 499	269	3.6	2.2	265	2.8	1.9
500 or more	337	7.8	2.6	337	6.9	2.5
By region:						
1. New England	251	.6	.7	251	.6	.7
2. Middle Atlantic	600	5.5	2.2	600	5.2	2.2
3. South Atlantic	814	1.8	1.7	814	1.4	1.7
4. East North Central	895	0.0	.0	898	0.0	.0
5. East South Central	482	2.8	2.9	480	1.7	2.2
6. West North Central	783	1.8	3.0	783	1.8	3.0
7. West South Central	806	5.0	3.5	845	4.2	3.2
8. Mountain	361	.8	1.3	361	.8	1.3
9. Pacific	704	0.0	.0	700	0.0	.0

[a] Sampling errors are stated at the 95-percent confidence level.

Note: Detail may not add to total due to independent estimation.

Table VIII.16: Distribution of Cost-Minimizing Changes in Insurance Coverage From 1983 to 1985 and Related Sampling Errors

Figures in percents

Coverage change	Hospitals	Sampling error[a]
Decreased per-occurrence limits only	7.0	1.7
Added self-insurance trust fund	3.6	1.4
Switched to claims-made policies	3.9	1.2
Added deductible or increased limits of deductible	3.6	.9

[a] Sampling errors are stated at the 95-percent confidence level.

Note: 1. The universe of hospitals was 5,783.

Note: 2. The balance of about 82 percent of the hospitals made no cost-minimizing changes.

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